MAKING BODIES: CESAREAN NARRATIVES IN MÉRIDA, YUCATÁN

By

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MAKING BODIES:
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This dissertation takes an anthropological approach to examine the social relations and ideologies woven around the cesarean through the narratives that women and physicians tell about their experiences in Mérida, Yucatán. Epidemiology and health statistics clearly show what most people know about cesareans: wealthy and privileged women get more cesareans than poor women who are supposedly at more risk. As such, the cesarean is more than a medical procedure: it is marked in social ways and distributed disproportionately in society. This anthropological study with a focus on narrative, rather than focusing on ways that childbirth is increasingly medicalized through the cesarean, examines the way that a medical procedure takes on meaning in everyday life.

As an urban ethnography, this study examines how the cesarean is variably interpreted and understood throughout the social landscape of the city. Mérida is a

geographic space, overlaid with many social imaginaries of class, race, ethnicity. In what ways does the social landscape of the city shape the form and movement of the narratives that women and physicians tell about cesareans? How do issues of ethnicity, language and sexuality influence decisions about cesareans?

The study consisted eighty-one formal, but open-ended interviews done with women and physicians throughout the city of Merida. The interviews were transcribed, coded and analyzed with ATLAS/ti: a qualitative data analysis software program especially appropriate for the interpretation of meaning in narrative and conversation. These interviews were analyzed and interpreted within the larger context of the ethnographic experience of daily life in Merida.

The study concludes that many women in Mérida use cesarean narratives as a form of labor in the reproduction of social bodies instead of using them to contest the hegemony of an increasingly widespread medical procedure. Changes in obstetrical practices are generally viewed as positive and desirable in the search for improved quality of life. Even narratives which focus on the malpractice or negligence in cesareans are shaped to delineate the patterns in the social body which went wrong. Due to the way the economy is organized, familial and friendship networks are crucial to survival, and the creation, maintenance and struggle with those social bodies is an important part of the work of mothers. In this way, the cesarean narratives shape social bodies: bodies which struggle in many varied ways for either the continuity or change necessary to negotiate the ruptures and economic crisis which are a part of everyday life in Mexico.

CHAPTER ONE
THINKING THE CITY THROUGH NARRATIVE

This dissertation examines the social relations and ideologies woven around the cesarean as an ever more common way of giving birth in Mérida, Yucatán through the narratives that women and physicians tell about their experiences. Cesareans are first of all a clinical procedure only in the sense that they occur in clinics, that they are legitimated as a means to save lives with technology and that they are carried out by professionals on anesthetized bodies. Cesareans are also childbirth, a life-changing event at which a fetus becomes a child, a woman becomes a mother, and many other people are drawn into the varied webs of family. This dissertation seeks to demonstrate, that in these crucial moments for the shifting patterns of reproducing a social body, cesarean narratives are a creative form of labor in a fluid system of social reproduction.

This dissertation is also a study of the ways in which global trends in cosmopolitan medicine both shape and are shaped by local conditions. Throughout the world, the cesarean is employed with ever more frequency for two primary reasons: philosophical changes in how the body is understood; and processes of institutionalization of childbirth which shift ideas about the times and spaces of childbirth within a particular constellation of economic conditions. This dissertation explores how individuals embody and come to accept as natural such conditions, in spite of the fact that trends to move childbirth into hospitals have been constructed disproportionately by those in positions of power. I also

am interested in how these patterns of power follow other patterns in the social landscape, opening spaces in which individuals create selves, bodies, social mobility and meaning.

The high rates of cesareans initially lead to explanatory frameworks often leaned on in moments of ambiguity or crisis in Mexico, sort of set of mythical meta-narratives that are used to illustrate or exemplify narratives about birth. These include frameworks that emphasize, for example, corruption, weak women and the perils of a modernity which comes contaminated from "the north." Academic literature, popular discussions, and scholarly conversations about the current rates of cesareans in Mexico will usually result in someone mentioning the famous *billete* (money) which is metaphorical for corruption and greed of physicians (their insatiable quest for wealth), or that women are just not strong and courageous like they used to be (lacking courage and want birth without pain)[1]. These explanations are so diffuse and so parroted, said with such stereotypical finality that they beg deeper exploration. This dissertation will examine these images in two ways: a) what are some assumptions about bodies and society that undergird these explanations? b) how are narratives about cesareans situated in relation to these other larger, shared meta-narratives?

Lastly, both of those questions are addressed within one deeper question. In what ways does the social landscape of the city shape the form and movement of the narratives that women and physicians tell? How do issues of ethnicity, language and sexuality

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[1] While I primarily refer to the inevitable course of conversation when people ask me about my purpose in Mérida and what the topic of my research is, there are also plenty of examples of these explanations in academic articles and newspaper sources written about the cesarean in Mexico. For examples, see articles in the conference proceedings, *"Cesáreas: tendencias actuales y perspectivas,"* published by the Comité Promotor por una Maternidad sin Riesgos en Mexico. Also see newspaper article, Excelsior, Wednesday, January 22, 1997. "El Lucro Impide a Hospitales Privados. . ."

interplay both in women's and physician's decisions about ideal births? Both surgical rooms and midwife homes are part of the same ethnographic field of childbirth. To understand that technology used in childbirth shows access to privilege is important to understand the relations of power between women, their physicians and their midwives over forms of childbirth and to realize that this access to privilege is interpreted, lived and desired in many different ways. In what ways are these explanations inscribed on the bodies of physicians who do cesareans, midwives who contest them, and women who give birth in this way? How do those enscripted bodies then create the social bodies that constitute the city of Mérida?

To answer these questions, I examine narratives and conversations about cesareans with women and physicians in the city of Mérida, Yucatán. It is important to understand that these narratives take place within the geographic and social relationships which both define and are constituted by the narratives about childbirth. The city of Mérida is a geographic space, overlaid with many the many social imaginaries of class, race, ethnicity with which people struggle with the patterns that make sense of daily life and sustain the social bodies configured within those patterns. Bourdieu names three ways to think about social groups that are useful in conceptualizing the social imaginaries which have such constitutive power in the city of Mérida: a) to privilege an analysis of relationships over definitions of people within categories that can be numbered and limited by ideas of who and who does not belong in them; b) to think of the social field within which social groups constitute themselves as a multi-dimensional space which goes beyond the relations of economic production; and c) to pay careful attention to the symbolic struggles that people engage in to represent the social world and the hierarchy within and among

the different fields (Bourdieu 1985). Within Mexican society, attention to the ways women creatively work with and struggle with the social body is particularly important, given the significance of kinship and political ties in the webs that sustain people economically and socially.

Epidemiology and health statistics clearly show what most people in Mérida already know and talk about in reference to cesareans: wealthy women get more of them. From the start, the cesarean is a socially marked symbol of access to the privileges of technology and medical resources. This does not mean that everyone wants them, or is willing to own up to wanting them. Many other social issues are also at stake: ideas about character and pain, ideas about how long birth should take and when and where it should take place; ideas about strength, fortitude, sexuality and what makes a perfect baby are all present either in stated ways through the narratives, or as the amorphous shapes of meta-narratives that need contesting through the representation of one's own experience.

During birth, a new being comes into the world, and the people in the constellation of relationships which surround the new child all shift positions. When women and physicians narrated their experiences of cesareans, they made choices about what to tell, and how to tell it to me. The naming of relationships with others: who was present and who was not; how people were helpful, and how they were not; the prestige or lack of it of the different people present; was one of the most important elements than ran consistently through the narratives. In this dissertation, I pay close attention to the ways in which social bodies (the constellation of shifting relationships which surround each person) are created, maintained and struggled with through cesarean narratives.

In order to do this, and show how the cesarean is socially mapped and shaped, it is important to describe the social landscape of Mérida. This social landscape is mapped on a specific geography and inhabited by people with particular histories. Fuentes, in his study "Appropriation of Space and Images in the city of Mérida", points out that space is both physically and territorially defined, often by the actions of the State and urban planners who demarcate certain ideas of social relations, but the people who use that space re-orient it, deform it, and made it adequate for their needs (Fuentes 1995:8). In the following section, I describe the city of Mérida and some of the ways that people map it socially.

Mérida

The city of Mérida (see map, Figure 1-1[2]), is both capital of the state of Yucatán and the primary city in Mexico's southeast, in terms of industry; the extensive communication and transportation networks with other parts of the peninsula; the sophisticated educational and medical infrastructure providing services to the entire southeast; a large number of modern shopping malls and numerous facilities for sporting and cultural events. Mérida was designated by the SUIP (Sistema Urbano Integrado Peninsular) as the primary city in southeastern Mexico for infrastructure and services. The cities of Campeche, Ciudad del Carmen, Chetumal and Cancún are the supporting cities to this

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[2] The Perry-Castañeda Library Map Collection. University of Texas at Austin. Http://www.lib.utexas.edu/Libs/PCL/Map_collection/map_sites/cities_sites.html#M .

regional system (Fuentes Gomez 1992:21). The last census of Mérida, put the population of the city itself at 612,261 and the municipality at 649,770[3].

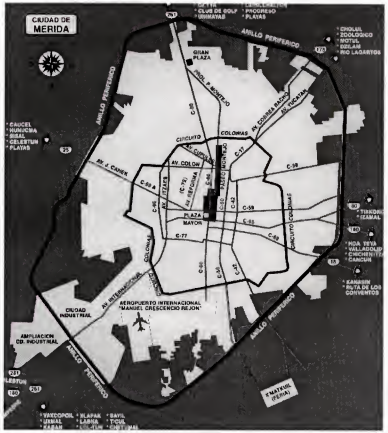

Figure 1: Map of Mérida, Yucatán.

Mérida From Within

One of the aspects of Mérida relevant to this dissertation is how both migration and growth have developed different maps of ethnicity that layer in different ways across the social landscape. Before the time of henequen[4] in the late nineteenth century, Mérida was

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[3] Conteo de Población y Vivienda 1995. Yucatán. Resultados Definidos. Instituto Nacional de Geografía, Estadística e Informática, INEGI, México, 1996.

[4] Also known as sisal, used for making twine or rope.

considered to be one of the most impoverished and remote cities of Mexico. By the end of the nineteenth century (1893-94) henequen represented 27.8% of Mexico's total exports. Mérida had developed into the fifth largest city in Mexico by 1921 (Fuentes Gomez 1990:49, 50) and certainly was one of the most prosperous. When henequen was replaced by wire, and then plastic twine and rope in the world market, the hardest hit in the peninsula were the villages and towns of the state. This accelerated what Burns refers to as a system of transmigration in which rural families established connections of different kinds with the city (sometimes migrating to Mérida, sometimes returning after a few months) forming a pattern of relationships between the towns and villages of Yucatán and the city of Mérida. "In comparison with other cities, Mérida had and has a population with strong connections with the countryside. In this way the Maya culture did not disappear when indigenous people moved to the city." (Burns 1993:75, 1992:47-49). In some ways, this relationship is well illustrated by thinking about urban population growth patterns. It is easy to think of Mérida as growing bigger and bigger, exploding on the peripheries unimpeded by rough terrain and consuming surrounding villages as it expands. The surrounding villages of Uman, Kanasín, Cholul and Caucel are also rapidly growing populations (Bolio Osés 1993:162), growing towards Mérida as well. Uman's population tripled between 1990-1995, and Kanasín has increased five and a half times. Between 1980 and 1990 the nearby city of Kanasín had already experienced a population "boom" of 12.7%, much higher than the national average. It is estimated that by 2012, Mérida will number over one million, and the towns of Cholul, Thadzibichén, Kanasín and Muna will be incorporated within urban spread just as Chuburná in the 1970's and the

ex-haciendas of Pacabtún, Chuminópolis or Wallis several decades ago (El Mundo July 8, 2000).

One of the frequent metaphors that people draw on to explain what is "Yucateco" is to describe some of the historical processes that shape the city. Practically all writings about Mérida begin with the description of the two names of the city: the name Mérida (which is itself is shared with two cities, one in Spain and one in Venezuela), and the Maya name of Ichcaanzihó. When Mérida was founded in 1542 by "El Mozo," the Spanish conquistador Francisco Montejo, it was built on the old Maya city by this name. This beginning is often quoted to illustrate a sort of "beginning point," or as Tulio and Ponce put it, "rebirth of a race and culture" (p.115) which is "Yucateco", both Maya and European, and not Mexican.

The terms so frequently used in other parts of Mexico and Latin America to denote the ways in which European and indigenous peoples have intermingled to create new social patterns of difference are used differently in Yucatán. The word "indigena" outside Yucatán usually comes paired with another local term (ex: Huichol, Lacandón, Trique). People who have left behind an indigenous identification in language and ways of dressing are called "mestizo." Those who do not have an indigenous past – either in the sense of identification, or in the sense of having "left" it behind – are sometimes referred to as "ladino" (more of a Central American usage).

In Yucatán, however, terms for indigenous and European people are laid out differently. The word for a person who is linguistically and culturally either self-identified or labeled as indigenous is the word "mestizo." The Maya words "*dzul*" or "*catrín*" are generally used to denote someone without Maya characteristics, but these

words are not likely to be used with non-Yucatecos or obviously elite Yucatecos. Only local academics, people promoting tourism and outsiders use the term "Maya" for the people locally known as "mestizos" (Burns 1995:77, Hervik 1991). When reference to "*indigenas*" or the more derogatory "*indio*" is heard, it is either in reference to indigenous peoples in other parts of Mexico, or a particularly pejorative way of speaking.

The term "*Yucateco*" is also very important and has subtle distinctions depending on who is using it and in what context. People in Mérida can be referred to academically as "*emeritenses*," as being from Mérida, but many people all over the ethnic map of Mérida and the state refer to themselves as "Yucatecos." The *Yucatecan* elites see themselves as distinct from elites that have come from other parts of Mexico, or from the Lebanese who have become very successful in the economic map of the city (Ramirez 1994). Many aspects of Mayanness are important to these Yucatecos: e.g., knowledge of Maya words, the presence of gardeners, household help and nannies who speak Maya and are asked to wear hipiles and look like mestizas. They will wear the *ternos* (the very elegant and expensive versions of the hipil), wear gold, and demonstrate knowledge of the "cultural" elements of a particularly Yucatecan history. It is as the cultural and historical elite with a combined European and Mayan past that they want to be known, not with the Maya of the villages and towns of the peninsula. This is illustrated in the words of a sixty year old woman who uses the term "Yucateco" as a synonym for *gente bien* (well to do people). She lived in Garcia Gineres (an old, established and beautiful

neighborhood close to downtown) as a child and remembers the social divisions of those times with nostalgia. In those times back then, people knew who they were[5]:

> The idiosyncracy of the Yucatecan is very special, very different than it is in other parts of the country. It used to be that for the *gente bien* from here would go to other countries to "culturalize." To New York. To Paris. It was so hard to go to Mexico because you could only go by boat and it took so long. There was no road. We only have the road since 30 or 40 years ago. So, you go to Havana, to New York. Logically there was a lot of distinction by class. Upper class and the poor class. More or less there was what you could call a middle class, but definitely, you could know and you could mark who was rich and who was poor. Not any more. It is all different now. Sixty years ago, or 55 or 70 years ago the Arabs came, the Syrian Lebanese who came with Turkish passports. They used to be marginalized, living over there on the other side of the city where the bridges were, you know the one on sixty-first and sixty-third street? Back behind there lived the Arabs and they didn't mix with the rest of society. Then one did it, and pulled all of them with him. They made a society club. They built a clinic. And now everything is even. A Yucatecan can marry an Arab, an Arab can marry a Yucatecan. It is different now. It is not like a club anymore, to get in the club all you have to do is pay. If you pay, you get in. Take for example, the Clinica Mérida. A bunch of those industrial people got together to make a first rate clinic, it even has a connection with some U.S. clinic. But it isn't a first class clinic. They just charge you first class rates and then they give you fifth class service.[6]
>
> Leydi Aguirre, Campestre, Northeast Mérida [7]

The word Yucateco has many other meanings in other parts of the city. To the Yucatec Maya of the peninsula who think of themselves as part of a rural and urban culture, who have a global understanding of how they are situated locally, and to whom

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[5] All people quoted from the interviews were given pseudonyms that more or less matches the ethnic and class patterning of names given in Mérida. Maya, Lebanese and names known to be associated with wealth or privilege were exchanged with others that are similar. The limits to which this is successful, or the accidental use of someone's real name are simply reflect on the limitations of my own knowledge of the complexity of these patterns. People who have published their ideas, or presented them in public forums are identified by their real names.

[6] All translations from transcribed interviews (transcribed in Spanish) and citations from books are my own unless otherwise indicated.

[7] See Figure 1-2: Urban Segregation, on page 12 to understand geographical locations.

an urban understanding of life has a deep past (Burns 1992a), the word Yucateco does not mean urban elites. In 1993 I listened to a midwife in the south of Mérida helping her children with their homework. She was explaining the concept of borders. "There is a border between Yucatán and Mexico," she explained, "just like the border between Mexico and United States. That is why we are called Yucatecos and not Mexicans."

Mérida and the Outside World

In addition to this dynamic relationship with the Maya population of the peninsula, Mérida has also experienced immigration from many parts of the world. In 1935 Hansen and Bastarrachea refer to the ways people came in from many other parts of the world during the late part of the nineteenth century and early part of the twentieth.

> All these new opportunities attracted immigrants and people from other states of Mexico. People from Cuba and the Antilles began to arrive in Yucatán as workers for the most part. Lebanese, Spanish and some Italians came looking for employment opportunities and to establish businesses. Some Chinese and Koreans were imported as contracted peons. We should say that even if these were not numerically strong, they began to confuse the old patterns about status, because they did not "belong" in any particular space (Hansen and Bastarrachea 1984:101).

In the last few decades, Mérida has also grown with migration from other parts of Mexico. The earthquake of 1985 serves as sort of a metaphorical emblem for the process of decentralization of population that Mexico is experiencing in the last decade. Long standing families of the D.F. move entire families to other regions of the country, seeking out the calmer, less dangerous, less crime-laden life of the provinces. In the last five years there has also been a significant number of people from Chiapas moving to Mérida, creating illegal settlements in the Ecological Reserve Cuxtal just south of city limits. The

mayor of Mérida points out that a 20% of the people who live in Mérida were born elsewhere. This is in contrast to the figures from the 1990 census, when only 10% of Mérida's population was born out of the state (Fuentes Gomez 1990:22).

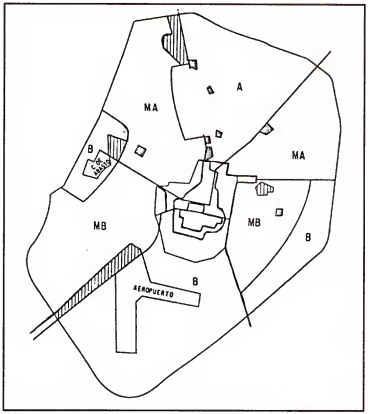

Figure 1-2: Urban Segregation. (Source: Plan Director Urbano de la Ciudad de Mérida, reproduced in Fuentes Gomez 1995).

Mérida's social landscapes are balanced on a north/south continuum that is considered to divide the wealthy of the north from the poverty of the south. Several demographic factors contribute to this way of understanding the social landscape. An article in the Diario de Yucatán pointed out the difference between high demand land prices for residential property in the north which can sell for as high as $750/sq. meter, comparing that to some lands in the south of the city that sell for as little as $25/sq. meter

(Diario de Yucatan, September 7, 1997). Fuentes Gomez (1995) uses the map below to illustrate how this was laid out by the "Plan de Desarrollo Urbano de la Ciudad de Mérida" (Urban Development Plan of the City of Mérida). I summarize his explanation of the map above to illustrate the social imaginary laid out in this way by urban planners.

> Zone 1: Central Mérida. Primarily administrative, touristic and commercial area with some residences in the old neighborhoods.
>
> Zone 2: North: [Corresponds to section labeled "A" (*alta*/high)]. Fourteen percent of the surface of Mérida and has twelve percent of the population. This zone has the highest incomes and the least population density.
>
> Zone 3: East: [Corresponds to the two sections to the east labeled MA (*media alta*/medium high), MB (*media baja*/medium low) and B (*baja*/low)]. Medium population density. Twenty percent of the population in this sector earn between $6 - 10 dollars/day.
>
> Zone 4: South. [Corresponds to section designated "B" (*baja*/low)] This area has sixty percent of the population of the city, with the highest population density and the lowest incomes (Seventy eight percent earn less than five dollars/day).
>
> Zone 5: West. [Corresponds to section designated MB (*media baja*/medium low), and M (*media*/medium)]. Very similar characteristics to the east.

The most poverty would be found in the south/southeast. In the growing corner of the northeast, however, the politically well-connected people buy up *ejido*[8] lands and convert them to a range of sub-divisions, some built for the wealthy and some for the upwardly mobile working middle class.

In another form of representing the lay-out of social space, Mérida city hall offices put out a map where neighborhoods are marked in categories ranging from *marginada* (the most economically marginalized sectors), to *popular* (poor working class), *media*

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[8] Communal lands owned by villages rather than by individuals.

(median income, working class) and *residencial* (wealthy neighborhoods, defined as such because they are supposedly uncontaminated by small businesses, peddlers, home-size markets, and little *cocinas económicas*). However, there are increasingly large sectors simply designated as *interés social* indicating that such categorization is gradually coming apart at the seams. *Interés social* refers only to the kind of bank loan needed to purchase the house, and is a category that no longer marks neighborhoods in easily definable ways, another example of how the city is not so easily described and categorized geographically.

Since 1994, NAFTA has contributed to the etching of the north/south continuum. While the effects have been felt throughout the city, the biggest monuments have been built in the north, with businesses such as SAM'S club and restaurants such as Kentucky Fried Chicken, TGIF, and Subway becoming ever more prominent. Carrefour, an enormous French supermarket, opened in the north of the city three years ago within a few feet of the old Hacienda Xcumpich - not given a name on either municipal or INEGI maps. Behind the huge government subsidized henequen processing factory, the old hacienda has a small school, small church and a little plaza. It still looks much like a sleepy small village. Since Carrefour faced east towards the commercial centers built up along the northward axis of Calle 60, very little changed in the small hacienda with dirt roads. For this tiny hacienda with in the northern reaches of Mérida, all this changed with the opening of the SIGLO XXI (Century XXI) convention center inaugurated with U.S.A. President Clinton's visit in 1999. SIGLO XXI faces south with one eye open to the marginality of the old hacienda, and suddenly the roads into the sleepy village have been re-paved, cement houses are being painted, stores are opening. Directly south of the old

hacienda is the urban neighborhood of Chuburná. Just thirty years ago it was also still considered a rural indigenous village and but it is now a completely integrated part of Mérida (Lara 1997:30). With its own cathedral and market, it is has some of the wealthiest homes of the city, alongside with the old style Maya homes with *solares* (home gardens) and half stone walls encircling the property. Referred to in the newspapers occasionally, as a site of rural/urban chaos, it represents some of the future of the little hacienda now practically in the parking lot of Siglo XXI, and on a large scale what is lived throughout the city of Mérida in different ways.

Social Dichotomies And The Mapping of Imaginaries

"Mérida has a one view towards the sea - outwards to the north," it is said, "and another that looks inwards to the Maya hinterlands." In that sentence are embedded bifurcated visions of modernity and tradition, future and past, the global and the Maya. Outwards and forwards, inwards and backwards are layered over each other and counterposed. When Redfield posited the city of Mérida as the urban end of a folk-urban continuum, his description implied a steadily increasing loss of Maya meanings in everyday life (Redfield 1941, Burns 1992a:46-47)

Two recent books on Mérida, one borrowing from the past and the other imagining the challenges of the future, also counterpose some of these images in their titles. The study "Mérida: Su transformación de capital colonial a naciente metrópoli en 1935," finally published in 1984 by Dr. Ansel Hansen, filled in the urban end of Redfield's continuum. Set in the 1930s during Hansen's fieldwork, it both looks into the old days of colonial life and into the future of the twentieth century, focusing primarily on social

stratification and how these patterns shape the city. Another book, "Mérida: El Azar y la Memoria", was published in 1993 by a group of architects and some social scientists. Counterposing the history of the city against a sense of chaos and change, they are more interested in the lack of fit between what planners map out in documents with such names as the *"Plan Regulador"* and "*Plan Director*" (Alonzo Aguilar 1993:272), and what a constellation of government offices, people's creativity, circulation of money and lack of it actually produce in the flows and patterns of what makes present-day Mérida.

These Méridas of the past and of the future, and other Méridas, unimagined by even the writers of these articles, form parts of the same urban space that simultaneously opens up and constrains the social bodies that inhabit it. People use imagined frames to shape social bodies: the ways they are etched, extended and erased within the possibilities and constraints of both the material form and the imagined social landscapes of Mérida. These imaginaries are formed as people move about the city, some of them in buses, some of them in private cars, each of those modes of transportation giving different impressions of the flows, patterns, people and landmarks. Patterns can be seen in so many different transactions that make up the city: where people shop (markets, corner grocery stores, supermarkets, mega-supermarkets, downtown or in the malls, etc.), what kinds of money they use (exchange of services, cash, neighborhood credit, bank cards, international credit cards), what kinds of food they, their patterns of entertainment, how they communicate with each other, how they work out the patterns of their religious lives, how they seek out healers, health services and ways to enhance their sense of well-being.

Anthropologists study the everyday life of the city, and let it speak, says Canclini, rather than looking at the structures and patterns that shape it (Canclini 1990:16). At the

same time, they are interested in the many voices, dialogues and silences that constitute the city. One of the ways to work at both of these tasks simultaneously is to refer to some of the patterns that people use to categorize, explain, and make judgments about placement and flows of people, patterns of wealth and poverty, and the ways that ethnicity is imagined and constituted. Increasingly, these patterns are oriented around "new forms of identity which are being shaped as a result of the enormous communications networks, the multiple rites and the access to urban goods that make us part of international 'communities' of consumers," and the new forms of racism and exclusion that these kinds of studies highlight (Canclini 1997). In this way, studying any one part of these consumer and communicative processes in the city is another way of making an attempt to imagine and envision the whole. The study of micro-processes can be every bit as tiny and small, and elaborate and complex, as the large global processes that frame them (Knorr Cetina 1981:21).

Social Imaginaries in the Mapping of Medical Care

To examine the ways cesareans pervade narratives about self and society, and medical opinions about individual bodies and culturally marked bodies, is to study one of the ways in which the imaginaries of the city are constituted. Some of the pertinent elements are a sort of mapping of the provision of private and public health services around childbirth, the multiple ways that people use them, and the physicians who work around and through the different health care systems. This mapping tells a narrative of the city of Mérida with multiple over-lapping systems, which different populations can then access.

In Mérida's private medical care, there are twenty six different hospitals/clinics in the city itself, and of these, six are large and well-equipped. IMSS has two hospitals in the city, the Centro Nacional "Dr. Ignacio Garcia Tellez" and the Hospital Juarez, and smaller clinics in neighborhoods in all the quadrants of the city. The Secretaría de Salud operates the O'Horán as the tertiary hospital, and the Centro Materno Infantil for local maternal/infant care. In addition to these (IMSS, SS, and private care), there is the military hospital. The majority of the big, private hospitals are located in the north of the city, as well as two of the IMSS hospitals and the Servicios de Salud hospital located to the west of the city. In response to complaints about a dearth of medical services in the south, IMSS has placed a large clinic close to the southern perifery. In the last few years, with a national grant specifically targeted at reducing inequity, the State Government started two new educational institutions, the Instituto Tecnológico del Sur in the small city of Oxkutzcab in southern Yucatán, and the Universidad Tecnológica Metropolitana, in a southern neighborhood of Santa Rosa. This will be the first university in the south of the city[9]. There are still no major hospitals in the south of the city.

In the introduction to a collection on cities and health in the journal Ciudades, Bertolloto writes about an interior segmentation within cities that allows for different levels of exposure to unhealthy patterns. "Vulnerability is socially distributed," he writes, "usually associated with the social differentiation that is already in place" (Bertolloto 1997:6). The poor of the city are left to gather in the least safe areas. Fuentes describes the distribution of contaminants in terms of airports, cemeteries, garbage dumps, and the

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9 IV Informe de Gobierno. http://www.Yucatán.gob.mx/informeiv/present.htm.

industrial areas of the city, all of which are disproportionately concentrated in the south of Mérida. The north has the highest percentage of green areas, extensive personal gardens, gated communities watched over by security guards, supermarkets, shopping malls, educational institutions, hospitals, and so forth, far away from areas of potential natural and manmade disasters (Fuentes Gomez 1990:52-53, 1992:24-25).

While the distribution of health services, institutions and vulnerability to contaminants shows one mapping of Mérida, this is often used to describe a social mapping as well. A physician says that his clients to the north of the city are infected with all the high technology problems of the U.S., including an increasing trend to use lawsuits. Meanwhile, he says, people to the south of Mérida would rather be bought off with a few thousand pesos than to press charges against physicians in cases of absolute negligence because they live in such dehumanizing misery that they no longer have human compassion. When he says this, he is using a grid of explanation that he assumes I will understand about the north/south distribution of wealth and other sorts of privilege markers in the city. This continuum begins from the Maya hinterlands far south of the city (deep south would be the forests of Quintana Roo), and the north points to the port of Progreso, to Cuba, the United States and Europe beyond the sea.

Dra. Dávila has a private office in the north, and compares two groups of women. First, she refers to the women who come "handled" by midwives as women who "know nothing, absolutely zero. They come here with complicated pregnancies and it is all the same to them if their baby dies, or if they die, there is no conscience of anything, they have no education. Whatever is done to them is fine with them." She compares them to a second group of women "of another level, who have more information about what they

should/shouldn't do, they come with their husbands to pre-natal care, hardly ever miss an appointment, and they talk a lot and ask lots of questions." Without stating it, she expects me to understand that the first women are from villages, that they speak Maya, and that they have not gone to school. She expects me to share a common cultural mapping of the city of Mérida that places under-educated, indigenous people outside the city limits, and educated, conscientious users of medical services in the north among her private clients. A resident in his third year at the O'Horán said it this way:

> Everything is really tied into the cultural question. Even five miles away from the city there is a marked socio-cultural difference. Here in the city of Mérida we have an important evolution in economic, cultural and all other kinds of terms. Even five miles away from here, it has not arrived, and the ideology of the people there is very mystical, very traditional. There are still midwives. They still think they have to have all the children that God sends them and it is still out of the question to have a woman be seen by a physician. Women still go to midwives and there are still a lot of midwives in those communities who attend the majority of the births. There is still this belief that pregnant women shouldn't take any kind of medicine, not even an antibiotic, there are a lot of things like that. The woman is still so subject to what her mother says, what her mother-in-law says, what her husband says, she is still so oppressed in this sense, she cannot have an opinion. When they get here to the hospital and we ask them about birth control, they can't answer if their husband is not present, they have no opinion. What I am trying to say is that there is still a lot of educational backwardness. This is all here in communities not even five kilometers away. The same thing as what happens in communities two and even three hundred kilometers away, it is practically the same thing.
>
> Dr. Utz Ucan, Medical Resident, O'Horán

At the same time, seen from another point of view, the north is a distant, cold place unfriendly to everyday people. A nurse in the Centro Materno, the maternity clinic in the center of the city, told me that she really felt sorry for me having to interview all those women in the north about their cesareans. She is used to being a public health nurse, and her worst encounters with people were in the north. In the south, she says, people open their doors, invite you in, give you something to drink. They are friendly, open and

courteous. In contrast, being a public health nurse in the north is terrible, people do not open their gates, would not talk to her. "Between us, and in a coarse kind of way," she tells me with a grin, "we call them *mierdosos* (full of shit)". Another physician tried to open a clinic in the north, but she then moved back to an office in the south:

> In this clinic we attend people from the south, the east and the west. From the north, basically no one comes. They go to the CMA, the Clinica Mérida. I put an office in the north for awhile, but I didn't like it. My patients wouldn't go there either because they like it here. Because it is here in the center, many of them can come by bus, they don't come in cars.
>
> Dra. Mirian Rivas Solís, Private clinic in the market

When Dra. Alvarez, another physician with her private office in the middle of the market, counterposes stoic "people from the village" with "pampered girls who are always avoiding pain," she is drawing a character sketch that builds from endurance and long-suffering in hardship and poverty to images of over-protected, pampered and fragile wealth. Drawing on this mapping of the personalities that develop under these oppositional kinds of framing, Dr. Marcos Medina, a physician in corporate private care, naturalizes it by saying it is a matter of evolution. "Really, people evolve over time. It just isn't the same thing to talk about people with few resources and a low socio-cultural level who are attended in public hospitals by students and interns." Throughout the interview, however, flows his ambivalence; the people of "low socio-cultural level" are women who are "more conditioned to pain, less conditioned to techniques, more realistic," and in comparison, he says, "high class women don't want to suffer, they are not used to pain, they ask me for the most powerful analgesics that affect lactation but they say they don't care." Poor women, he says, want to go home the next day after a cesarean and have no complaints. Wealthy women are, in contrast,

> . . . attended by twenty thousand childbirth educators, eighty thousand other people, for a perfectly natural process. . there you have her mother calling us on the phone to come see her daughter because there is a spot of blood, and she had something that no one knows what it is. For us it is a torment to attend these people. They treat us like their slaves. That is the truth.
>
> Dr. Marcos Medina, corporate private care.

The results of this "evolving" might be unclear to him, but his words express a great deal of ambivalence about what it means for a woman to become wealthy and privileged, to move from one cultural level to another. But that a historical process of evolving is in place is commonly understood.

The ambivalence he is expressing is because the different ethnic, cultural, socio-economic mappings of the city are not understood or experienced in the same ways. The layers do not match neatly. Sometimes they are more interesting in the moments when they collide and fragment the conversations. Dr. Gallindo Luján works both in corporate private care and in the public sector, and says that a certain private hospital in Mérida is as good as any site in United States and Europe, that the clients who go to those hospitals are "healthy people without problems," and that the public hospital attends people who "have never seen a doctor, at most one or two times, with malnutrition, sometimes with toxemia, with terrible problems of anemia. Patients, in other words, with a lot of difficulties." He is mapping wealth with health and poverty with sickness, forgetting for the moment that the topic of the interview is why cesareans are so high in the private sector.

Doña Juana Maria Canché, a midwife in the deep south of Mérida, lives quietly among friends and neighbors along the famous road of "42 South" which has a local music band named after its metaphorical power to stand for a region of danger and

poverty. Conversation with Doña Juana breaks up social knowledge of the city in two interesting ways, representing in a small way how people's lives criss-cross the imaginaries on a daily basis. The conversation is about how useful it is that she can speak Maya with her clients. She illustrates the cosmopolitan nature of being indigenous in Mexican society when she remarks ruefully that she really should pick up some more indigenous languages, because she gets clients from different parts of Oaxaca and Chiapas whom she is unable to understand, and they just have to use a lot of hand signals and depend on translation through husbands. Not fifteen minutes later she is telling me about the birth of one of her nieces who is now a physician in Mérida, and who contributes to the family well-being by offering surgery at cost. A few months later I see this niece (a well known plastic surgeon) featured in the Diario de Yucatán (October 20, 1998). The article quotes her as saying that Yucatán leads the nation in having some of the best facilities for plastic surgery in all of Mexico and that "aesthetic surgery has become the most rapidly expanding industry in the medical community during the past decade." Career, consumer, kinship and communication decisions by people all over the city are running strong currents through old imaginaries, creating the hybrid cultures that Canclini celebrates (Safa 1992, Canclini 1990).

Imaginaries are durable goods however; they live on beyond the circumstances that create them. Mérida, I am told frequently by those who wished to teach me the rhythms and characteristics of the city, is a conservative city where both the mayor and the major newspaper belong to the PAN (Partido de Acción Nacional), the old-style Catholic, conservative, but opposition, political party. It is thought of as a *provincia* by the people in central Mexico: one of the hinterlands of Mexican society where crime still has a soft

glove, where no earthquakes hit or volcanos threaten, where cultural interminglings are quaint and beautiful, and at night jarana dancers and Yucatecan guitarists play under amber lights for the city's cultural elites, the tourists, and the young couples and families crossing the transportation systems of the city for one reason or another. Imaginaries in the provincias disintegrate a little slower, perhaps, than they do in the center of the Mexico that Canclini writes about, one of the biggest cities of the world. In Yucatán, they retain constitutive power and are firmly embedded in the social distribution of wealth and well-being, vulnerability and suffering.

Methodology

To understand people's use and knowledge of the space of the city in this way, and to imagine the cesarean as one of the medical commodities that is both consumed and then represented in different ways according to positions in the social landscape had several methodological implications for the design of the research. The focus is on narrative, and the way people choose to represent their birth experiences through the stories that they tell about their own experiences, and about others. I followed the narrative trail through the interviews, asking women to simply "tell me about your cesarean".

This narrative trail led into many arenas which can not be addressed in this study. To illustrate the many changes taking place in society which have led to the increase in cesareans would require several different studies with different conceptual and analytical tools. The insitutionalization of childbirth is accompanied with many changes in how childbirth is understood, in terms of time, space and the kind and form of resources

expended. These processes come up so frequently within the narratives, that it is important to address them briefly.

First of all, is the importance of examining the economic aspects of institutionalization - the money flows of childbirth. It used to be, in the not so distant past and in some places of the present, that a woman's family would give the midwife part of their farm produce, honor her with due respect on village streets, consider her an honored figure at baptisms and give her small gifts through out the years following a birth. Hospitals, multiple forms of health care mean fees for services provided either paid for by families or subsidized in some way by national and local health services. Economic exchanges imply transactions that are clearly understood and demarcated by the participants, and can lead to lawsuits, etc. when the terms are not followed, or are unclear.

The "money" argument used against high cesarean levels by activists and international health agencies is a very persuasive one: people and insurance agencies pay more for cesareans, governments spend more in the institutions they create to deal with maternal/child health, and the labor and technology invested in cesareans is much greater than for vaginal birth. Capital, however, is also tied up with time, efficiency and the creation of institutions to deal with childbirth in factory-type modes and is not simply spent, but also earned. Where do the trails of government spending and profit go?

Money is intrinsically linked with time, and the hours and minutes of childbirth have been re-designed to fit the needs of hospital space where many women are attended simultaneously, where many physicians and nurses work by shifts. The physiology of birth is now mapped against a clock, the steps in the process clearly demarcated to indicate when the expected norms do not line up properly, 'normally' in any one woman's

body. These norms are created in far away places: in the medical research (or lack thereof) in technologically advanced nations, and in the offices of health planners who are accustomed to dealing with international health agencies. Normativity and "risk" are measured in hours and minutes. Over and over physicians and childbirth educators would point out to me that the key issue in cesareans is not money and doctor's greed, but time. One physician said that there would be more natural births if physicians would be paid according to the time they invested in each woman's birth. In that case, he said, natural childbirth would cost twice as much. Cesareans can be done in a half hour some say, others say forty five minutes. Midwives say what is wrong is that no one waits for the "hour of God" anymore, doctors precipitate birth with inductions before the child is *sazón* (baked, ripe) and end up doing cesareans because neither the mother or baby is ready. Childbirth educators claim that the new physicians don't have patience, they don't know how to wait like the old *parteros* (old style obstetricians who attended birth) knew how to do. A physician can attend multiple birthing women in one morning if he arranges things right, and then he has time for office hours in the afternoon. Time and efficiency. Time to sleep, time to go home, time to earn more money. In the fall of 1997, I was shown a Spanish version of Parent's Magazine, "Padres e Hijos". The cover story was "Cesareans in Seven Minutes: a new technique." Developed in Germany, tested on one hundred women, the author is convinced that this new way of doing surgery will shortly be more available for women throughout the world to whom "the time factor is vital (Parrondo 1997)."

The institutionalization of childbirth involves (among other changes) a way to standardize the procedures in childbirth that will fit with the reconfiguration of space

used in childbirth, the patterns of time, and the costs involved. While these factors are of utmost importance to understanding the increase in cesareans, and references to these issues will be made over and over again in the narratives, the focus of this dissertation is about the shifting patterns in social relations in cesareans, and how that influences the way women and physician think about cesareans.

The following section addresses the intertwined nature of three elements of methodology important in this study of cesarean narratives. 1) The conceptual frameworks within which the study was designed, situated within the anthropology of reproduction with attention to the body, embodiment and narrative. 2) A description of the field methods and the process of research. 3) A description of the analytical process used to arrive at this final written format.

Conceptual Frameworks

> *Representations of birth, received through conversations, images, or written words, decisively shape our imaginings. Pfeufer Kahn 1995:38*

The Body as a Heuristic Device: The body was an important heuristic device in the theoretical/methodological design of this research. Throughout the interviews I asked questions about the lived experience of the cesarean, what it felt like - emotionally and physically. I paid close attention to how people talked about their own bodies, and other's bodies - what words they used, which metaphors. Writing and thinking on the body reaches across disciplines and is an important part of debates in anthropology, literature, philosophy, and sociology, etc. I do not attempt here to synthesize, explain, or even understand how the many strands in these discourses interweave, but will describe

how the parts of these discourses shaped the methodological presuppositions and the subsequent modifications to my research questions.

I was interested in the language of flesh, blood, and bones, how would women and physicians in the different points of the social landscape of Mérida "write the body" in how they represented their experiences of cesarean sections? There are a number of dichotomies implicit, if not explicit, in that sentence that I wanted to deconstruct. First of all is the supposition that an embodied space can not be a space of words. Secondly is the question of what "embodied" means in the context of the social landscape of the city.

Embodied Words: The supposition that an embodied space of flesh, blood, and bones is not a space of words has been under challenge for a few decades now in the anthropology of reproduction and the theoretical work on the body to transcend the body/mind - nature/culture splits (see below). Language/writing itself has been represented as a deeply gendered domain in philosophical traditions which left the production of thought to men and the producing of bodies to women (Pfeufer Kahn 1995, Minh-ha 1999).

One of the uses of the "body" in feminist theory and methodology has been 1) to re-define the "body" not as a passive nature juxtaposed to, and lesser than, an active mind, and 2) to begin to understand how the body is both a social and discursive space (Birke 1999:43). What is the language of birth?

> Western culture tells about *the birth of language, the birth of cities, the birth of nations*. In each case, the words *the birth of* gives generative power, belonging to the natural world, to the world of human invention. But what about a language of birth? For the phrase *the language of* holds generative power as well. (Pfeufer Kahn 1995:5, italics in the original)

In the last few decades, the words around childbirth have been embodied, with more and more writing by women from within the experience itself to challenge the expertise of previously written obstetrical tomes. The bodily experience of childbirth has also been increasingly worded - with a increase in popular and academic space for childbirth stories. Cesareans, however, are usually represented as a moment when childbirth is removed from the terrain of the "natural", and placed into a technological and patriarchal space of obstetrics. It is often portrayed as a space where women lose agency and voice. (For example, see Blumenfeld Kosinski 1990, Churchill 1997, Davis-Floyd 1996, Gaskin 1977). In what ways does language mediate this move as well? What happens if women create a discursive space around the embodied sense of the cesarean, a place to speak from how it felt, what they thought, the actual experience of the cesarean and their response? What kind of narrative would be written then? How would the narrative be different from the medical narrative of the failure of respective parts of a woman's body to give birth, a calcified placenta, a tight pelvis, lack of progress, a cervix that just doesn't dilate, a womb that does not know when to release a baby? What would women say about their sexuality, their decisions, their own feelings (in all the range of feelings that are possible), if they had a non-medical space to speak these words? How could another narrative be written other than the appearance of an anesthetized body on a surgical table, awaiting the deliverance of the surgeon's knife? Where would these stories move out from the individual body into the social body and the body politic described by Lock and Scheper-Hughes (1996)?

The mid-twentieth century U.S. women's health movement was shaped by women who spoke out from their own personal, embodied experience to challenge the script of

medical science about their bodies. Much of the call for "voice" came from the space of the women's health movement, and much of the critique of cosmopolitan medicine[10] that has found an ever-broadening academic space was born in the disjunction between the way women described the experience of their bodies and the shape of obstetrics as it was developed and institutionalized in the United States. The social science research that accompanied this movement was designed around women's voices in interviews, constructing from that worded space both a philosophical critique of cosmopolitan medicine and a cultural critique of the enactment of that medicine as it was designed around a culturally constructed understanding of women's bodies. (For a few examples: Arms 1981, Ashford 1984, Boston Women's Health Collective 1976, Davis-Floyd 1992, Hubbard, 1990, Jordan 1993 [1978], Artschwager Kay 1982, Martin 1987, MacCormack 1982, Oakley 1980, Rich 1977, Romalis, 1981, Rothman 1982) Morgan defines this moment in history as a struggle over epistemic power: a time in which "women challenged and changed dominant medical beliefs and research findings" (Morgan 1998:113). It became increasingly apparent that what was at stake in much of these ever-

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[10] I use the term cosmopolitan medicine after the example of Leslie (1976). "Cosmopolitan" denotes both the extent and universality of the ways in which the form of medicine referred to here has become institutionalized worldwide, and at the same time recognizes the uniqueness of the many formulations and usages it has taken on in different countries and regions of the world. I also choose the word "cosmopolitan" out of some discomfort with the other terms available: "Biomedicine" places too much of an emphasis on the supposedly biological science foundations: whereas the study of childbirth and cesareans demonstrates over and over the many ways in which the medicalization of many aspects of human life has escaped the confines of a biological science. The use of the word "academic medicine" ignores too many professionalized medicines both in Asia and other medicines with long histories such as chiropractic, homeopathy, etc. The use of "Western medicine" has long outrun its exclusivity: it is used in so many parts of the world in creative ways. "Allopathic medicine," while well understood within Mexican anthropology is less commonly well-known and understood in English.

expanding debates over childbirth, over obstetrics and health care for women went far beyond the shape of medicine. It is a struggle over what constitutes knowledge and what/who makes that knowledge authoritative (some examples: Harding 1991, Jordan 1993:152-154, Rosser 1994). This is ironically illustrated by a quote from William's Obstetrics, the authoritative medical text for obstetricians.

> Obstetrics is the branch of medicine that deals with parturition, its antecedents, and its sequels (Oxford English Dictionary 1933). It is concerned principally therefore, with the phenomena and management of pregnancy, labor and the purpureum, in both normal and abnormal circumstances. In a broader sense, obstetrics is concerned with the reproduction of a society. (William's Obstetrics, quoted in Davis-Floyd 1992:45)

Looking for embodied words, for narratives, for the language of cesareans is not simply a question of who has them, who negotiates them, and who casts the terms of their usage. It is about the power to represent reproduction of society. This research was a deliberate search for the language and terms of the embodied dialogue about childbirth through cesareans: regardless of whether the words were formed from the bodies of cesareaned women, or the bodies of cesareaning physicians (male or female).

There is a crucial distinction, however, to make at this point, between a search for embodied words from specific subject positions and a search for the terms of a dialogue which is negotiated in multiple ways by social actors who can and do take different positions in the dialogue. This next section shows how anthropology began to look at the issue of "local biologies" in reproduction, how that became increasingly defined locally, and some of the problematic that raises for this research.

Embodied Dialogues and Difference : The second question about the body is how this body is social. What does it mean to be a body in the city of Mérida as compared to a body in the city of Tegucigalpa, or Bombay or Palo Alto? Lock raised the question of local biologies from her work on menopause in Japan. Exactly what is the "natural" or "biological" body, in relation to how it is situated in different physical and cultural environments? How can the physical responses of menopause, the language formed to understand these physiological processes, the political-economic structures in which women's work is embedded, and the local shape of cosmopolitan medicine be created in different ways in different contexts? (Lock 1993b) Beyenne also asked this question in reference to the varying ways in which Yucatec Maya women and Greek women experienced menopause (Beyenne 1989).

This question about how local biologies are shaped in different environmental and physical settings is also asked, in others ways, by how bodies in similar environments are situated in relationship to each other. How are the local social bodies of people in the city of Mérida constituted and represented in distinctive parts of the city? Much of the work on anthropology of reproduction cited above was concerned with the social environments of the women who were raising the questions about their own embodied experience within a political struggle located in the white middle class environment of the U.S. in the mid-twentieth century. The work has since been critically evaluated by those who raise questions about how reproduction in society is stratified, what are the patterns of privilege and wealth and how are the "embodied" experiences fractured by questions, not only of geography and history, but of class, gender, and color (Collins 1988, Ginsburg and Rapp 1995).

To understand that embodied experiences are fractured by different positions in society can shape research methodologically in two different directions. In one format, groups of subjects can be defined by a certain set of variables that specify their common positioning, and a "voice" or a "narrative" can be shaped from that group of people in opposition to another group defined by another set of variables. In this way, research can be presented as showing the racially, ethnically, or gender-marked categories of difference. This leads, however, straight into the problematic of defining people by categories, rather than by the relationships in which they are situated.

This research was initially designed around groupings of women and physicians from the three different health systems in Mexico, in this way representing some of the distribution of poverty and privilege in society. While I have no wish to deconstruct the patterning of poverty and privilege which shape people's lives in very material ways, it also was not possible to represent these patterns with people in fixed positions. The overlap between the systems, the moving back and forth of physicians through all those categories, the varieties of women who used each of the systems either simultaneously or sequentially did not fall into the patterning that I could conscientiously present as belonging to any particular subset of people. Menéndez (1997) recently wrote a critique of the use of "point of view of the actor" in anthropology. He highlights the errors of essentializing of any "voice" as representative to any social grouping by questioning which voice needs to be heard, considering first of all that all voices are relational and situated within social bodies. He shows how it is possible to continue the fracturation of whom to represent down to the smallest entity of each individual self and run the risk of atomization of identity. Once there (at the great panorama of difference which is lived in

each individual), then each individual is tied through webs of identity in different ways at different times, one individual will not have the same voice at each and every moment. The fracturation of voice is not only split with gender, social class, ethnicity, and race (in the different montages they are created with), but also split horizontally in relationships, and can even be incompatible at times. Much like Bourdieu argues in his article on social groups, Menéndez writes that instead of a positional view to the subject, it is important to imagine them relationally (p. 256), and emphasizes the "methodological necessity of orienting a search towards diversity and difference and not for homogeneity" (p. 252). Otherwise, undue attention to "voice" is really about participating in the silencing of the majority of voices present (p. 255). In this way, social actors, rather than inhabiting fixed locations, are parts of constellations of difference that they have to struggle within.

One of the ways to search for the heterogeneity is precisely to examine the ways that narratives are situated within larger dialogues and conversations about society. Tedlock and Mannheim recommend thinking about culture as inherently dialogical, taking off from Jakobson's argument that language itself is dialogical, the scene of production for shared language structures (Tedlock and Mannheim 1995:1). The emphasis on this shared dialogic ground, necessarily, however, lifts the attention from a constellation of individual speakers to the shared languages and narratives.

> A dialogical ethnography cannot content itself with the celebration of a multiplicity of voices, not matter how diverse their social origins. One of the key challenges is to reformulate the problem of the locations of culture within a social ontology in which neither individuals or collectivities are basic units. Thus reformulated, the task becomes one of identifying the social conditions of the emergence of linguistic and cultural forms, or their distribution among speakers, and of subjectivity itself as an embodied constellation of voices. (Tedlock and Mannheim 1995:8).

It would be a mistake, however, to think of this shared dialogic ground, this "embodied constellation of voices" as a sort of solid collectivity. It is really about focusing on the fluid and interactive "interstices between people" (p.8). The fact of being shared does not take away from the ways in which that can be contested. Stern, writing about the Guatemalan refugees in southern Mexico, writes, "all verbal behavior, whether national narratives, testimonies, or oral histories is an indicator of social processes that illuminate social interaction and not simply verbal behavior. The contribution of anthropology is to understand this cultural production within a historic context and a contemporary field of power" (Stern 1999).

How do the epidemiological patterns in cesareans map out in everyday women's lives and what happens when they are contrasted to the mapping of the different forms of social privilege? What are the different positionings and combinations of these possible interstices within the city of Mérida? How would the workings of social privilege, mapped through discourses about ethnicity, class, and gender, be expressed through the narratives of cesareans in the voices of the privileged and under-privileged women who have cesarean scars inscribed on their bodies, and the voices of the physicians whose hands hold the scalpel? How do you describe the social mapping of hegemony and difference when they are constrained in the same spaces? And how do you follow the patterns of meaning that people create off the edges of the domesticated silences?

In an effort to convey this dialogic space, I refer sometimes to meta-narratives to explain the shared sense of imagined ideals, or cultural patterns that people I interviewed often seemed to be contesting or referring to for a sense of authority in their own narratives. I refer to discursive patterns which both women and men, birthing mothers

and physicians use to situate themselves and others and negotiate the terms of their social positioning to the edges of their abilities where they meet the framing of themselves. I am referring to the sense that people have of the birthing ideals that circulate, and the struggles that frame their own tellings, in much the way that Chase refers to "cultural discourses."

> My interest lies in understanding relations among culture, narrative, and experience – in understanding how women make sense of their experiences by narrating them within a particular cultural context. (. . .) My (own) narrative shows that as women recount their experiences, they simultaneously draw on and struggle with various cultural discourses – networks of meaning – about individual achievement and inequality. Through that narrative process, women construct self-understandings that both shape and are shaped by those cultural discourses. (Chase 1995:x, quoted in Gubrium and Holstein 1997:202).

In this way cesareans are a dialogue between bodies [(individual bodies and social bodies and the body politic (Lock and Scheper-Hughes 1996)] and constructions of pathology. "Illness is essentially dialogical," says Good (1994), "it is 'synthesized' in narratives. . . fraught with gender and kinship politics." It is social, imaginative and political (p.173). Veena Das (1994) defines health as a socio moral construct involving power, justice, and pain. When we imagine cesareans as taking place in a web of relationships (located in individual and collective bodies, represented by voices both fractured and relational), rather than solely the illogical outcome of an abuse of technology, we can understand how they are dialogical, a space in which women and their doctors negotiate the very delicate webs of gender, health, power and pain in Yucatán.

Narrative: To seek out this dialogue, I "followed" the cesarean narrative both through language and place. "The narrative use of language," says Hymes, "seems universal,

potentially available to everyone, and to some degree inescapable" (Hymes 1978:32). Labov also pointed out how narratives are particularly accessible around dramatic and life-threatening incidents, and therefore are good tools for studying natural speech patterns (Labov 1972 quoted in Burns et al 1991). Cesareans, as dramatic and life-threatening incidents which get told and retold, are often previously storied events - shaped for many different people and in different contexts (Pollock 1999:83). The primary point of Hyme's article is to question who has rights to think and express thought in narrative and develop skillful performance (Hymes 1978). This sociolinguistic work in the uses of narrative and how thinking is narratively shaped is a precursor to a recent upsurge in social science research methods which uses narrative both as a way to examine aspects of everyday life and personal experience and as a way to examine more general meta-narratives of cultural discourses and philosophical approaches to research. (For a few examples in social science research: Aggar 1998:176-178, Gubrium and Holstein 1997; in anthropology: Marcus 1998, Tedlock and Mannheim 1995; and in medical anthropology: Kleinman 1988, Good 1994, Mattingly 1997.)

Narratives, therefore, have many and varied uses, purposes, and definitions in both the social sciences and the humanities. For the purposes of this dissertation I am interested specifically in certain aspects of narrative. First of all, I focus on narrative in an oral and informal sense, an interactional space for a telling, not a written product that can be analyzed for internal structures. These narratives were verbal moments, small snapshots of events. The way people choose to tell their stories about the cesareans involved their highlighting and selecting information they considered appropriate in the context of the interview.

In Yucatán there is a strong narrative tradition, informed by what Burns refers to as a "social context of narrative performance in Yucatán" in which the telling and sharing of stories is an important part of everyday conversations. "Stories, myths and verbal art are woven much thicker into the everyday lives of Maya people than in societies where storytelling is always seen as a special event" (Burns 1992b:389). Burns explores how narratives are deeply embedded in a dialogic tradition of speaking in which narratives are expressed through conversational exchanges rather than being done as monologues as in other cultural traditions. Interested in the various speech genres, he examines this within the context of the dialogic nature of storytelling and the creation of narratives (Burns 1983). Tedlock and Mannheim also show that in addition to the persons creating a dialogue, all speaking is also "situated within the world" in multiple ways. "Any and all present discourse is already replete with echoes, allusions, paraphrases, and outright quotations of prior discourse" (1995:7), situated within "specific social, institutional and historical coordinates, all of which color the interaction at the same time as they are reshaped, to greater or lesser extent, by that interaction (p.9)." In addition to narratives being created through a dialogic encounter, they are also situated in a dialogic way with meta-narratives.

Second, because of my interest in how people situated their narratives, I wanted to hear the ways people explore questions of meaning and social relationships through the narratives, rather than focus on content or structure. Third, I am interested in both the long birth stories told about cesareans as well as the "short accounts that emerge within or across turns at ordinary conversations" (Reissman 1993 quoted in Gubrium and Holstein 1997:147). Four, narratives were embedded in explanations and surrounded in

conversations by sentences that highlighted certain moments, opinions, relationships, that appeared as illustrations of the nature of the actors, the context and the places involved as the background for the narrative being told. While these narrative comments ride along the margins of the interview conversation, they are part of the art of storytelling, and as such I include them as a part of the narrative of the cesarean itself. Lastly, I was particularly interested in how the cesarean narratives both illustrated and constituted the social bodies of individuals, families, and the social landscape of the city of Mérida. As such, understanding the body as inherently social and narratively shaped was another important aspect of this research.

Field Methods

In Mérida, one of the key ways of understandings someone's social position is where they live. People make critical choices (or have them made for them) about their social positions by where they choose to own, rent, borrow or scavenge a place to live. As such, my first priority was to seek out women in all quadrants of the city, placing a pin on a map of Mérida that hung on my office wall to make sure that the interviews were geographically spread over the physical landscape of the city. Throughout this dissertation, people are identified below the textual quotes in two ways. First, with a pseudonym that represents the classification of names. Maya, Lebanese and other names known to be associated with wealth or privilege were exchanged with others that are similar (see footnote 5 on page 9). Second, with the name of the neighborhood of the city

where they live. For those unfamiliar with the city, I add a note mentioning the quadrant of the city and refer to Figure 1-2, Urban Segregation, on page 12.

In the following section, I address two aspects of the field methods used in this research: my own lived experience of the social spaces of Mérida and cesareans, and the interviews which are the core of this research.

Ethnographic Participation: The ethnographic field for childbirth in a large city must be conceptualized large and experienced small. Childbirth takes place across all social fields, and throughout family life in all its variety in the city of Mérida. It is profoundly shaped by the forms of knowledge (institutionalized, public and private, midwifery, childbirth education, household commentaries, popular literature and folktales, etc.) which circulate about childbirth. The ethnographic field extends in all geographic directions of the city, throughout the imaginaries of how it is lived, and refracted by the ways in which women negotiate the different advice patterns, services, and institutions shaped around childbirth.

Initially, I thought that the negotiation of these different social bodies in the city of Mérida would come fairly comfortably to me. I speak spanish fluently, and spent many of the first sixteen years of my childhood in a small indigenous village of Oaxaca, also living from time to time in different parts of Mexico city. As an adult, I sent three years in a village on a logging trail in Bolivia where my neighbors were indigenous people from all different regions of Bolivia, and another three years in the out-lying reaches of Santa Cruz, Bolivia. However, just as for the people I interviewed, it is not an accumulation of certain number of categories or identities that make dialogue possible - but the particular

constellation of patterns that each person brings to the interchange in the interview process. Negotiating the different social spaces of the city required placement within it. This brings a whole set of challenges not traditionally addressed in anthropological research which has generally focused, not on the interspaces between social groups - but on identification with certain groups of people.

Anthropologists in cities, hoping to understand processes that cross social spaces, must do more than embody new identities in order to live and understand them from the supposed inside-out, the mystique of the old ethnography in which anthropologists embody new languages, new foods, new yearly cycles, and understandings of climate. They did so from the position of having an unmarked social body, leaning on the invisibility of their previous existence. An important part of my research was to "study up" as Nadar (1969) recommends, to understand cesareans and bodies from the point of view of the women who most frequently get them, and the physicians who most frequently do them. My own position in the city, as a researcher affiliated with the University of Yucatán, as the mother of three children in private primary, secondary, and high schools, as spouse of a scientist in a research institution, and as an inhabitant of a northern sub-division who drives a car, enabled my movements in many of those social spheres.

This also shifted the conditions of my movements in social fields I had negotiated quite comfortably during my M.A. research in the south of Mérida with midwives and their clients. Now I had social markings and placements I did not have previously. I was now known as a researcher from the University of Yucatan - different from 1993 when I was a gringa who came over, took afternoon naps in the hammock and was constantly fed

because everyone knew I didn't really have a 'home'. Now everyone knew I had three children to go home and cook for in north Mérida: three children who go to private schools and speak Spanish with a north Mérida accent. The friendships I developed during my M.A. research were invaluable to this research and key to my ethnographic knowledge of south Mérida.

Marcus refers to the new requirements for ethnography in multi-sited research, or single-sited research located in global systems. He mentions that the "constantly mobile, recalibrating practice of positioning in terms of the ethnographer's shifting affinities for, affiliations with, as well as alienations from, those with whom he or she interacts at different sites constitutes a distinctly different sense of 'doing research'" (Marcus 1998:98). One is simultaneously more aware of the overlap between social bodies in the urban landscape and the contradictions of negotiating the gaps between them.

In addition to the spaces I inhabited, two experiences of offering a service were also definitive for the way I did interviews and read the transcribed texts. First of all, I attended several midwife training courses done by Servicios de Salud, invited by one of the nurses to be an informal photographer for the events. Sitting in the audience, joining in informal conversations during breaks and meals, I could observe how physicians and nurses constructed their presentations to the midwives based on the intersection between their own knowledge of hospital birth, and their perceptions of what midwives know and do. Sitting in the audience also enabled me to hear midwives' dry commentaries and under stated stories in the background.

Over the period of several months, I translated childbirth education classes for an English-speaking woman from Hong Kong and her husband who was a high-placed

executive in a local maquiladora. I was able to accompany her until she was wheeled into surgery, at which point the physician stated flatly that there would be no need for translation. During this time I both took note of the content of the childbirth education classes and watched her reactions to and struggles to understand a foreign system of childbirth, and people's reactions and suppositions about her "inevitable" cesarean.

Lastly, I observed one cesarean. My research interest for this study was to understand the ways in which people represent cesareans and the ways in which they choose to story the experience. I had no plan or wish to filter those narratives through my own perceptions of "seeing" a "real" cesarean. The physicians I interviewed, and the childbirth educators for Mérida's privileged women, did not see it that way, and in the end I agreed to observe one. The experience did influence my subsequent bodily and sensory reading of the narratives in two significant ways.

1) I finally understood why women repeatedly and consistently told me how terrible it is to stand up for the first time after surgery. In spite of being repeatedly told otherwise, I had still imagined the baby as lifted or maybe tugged from the incision, and could not imagine how profoundly all the internal organs are lifted, moved, and pushed around, and how the many layers of the body must be re-stitched. Subsequent readings of the narratives were accompanied by a sort of empathetic shudder and compassion I had not felt before.

2) I could not have imagined the almost ethereal sense of art in the movements of both the physicians doing the surgery. Motions were memorized like an intricate dance, the synchrony of mind and movement was fluid and graceful and full of the intensity of responsibility. I found myself, standing in the midst of gauze, blood, masks, white lights

and blue uniforms, reflecting on the term "the art of obstetrics." It is really important to realize that, in the struggles over the spaces, times, and skills necessary in childbirth, are also embedded struggles over who experiences the art and artistry of childbirth.

Interviews: I did eighty one formal, but open-ended, interviews with physicians, residents and nurses, childbirth educators, midwives and women with cesareans. All interviews with women ranged from forty five minutes to one and a half hours. In two cases, the interviews lasted over three hours. Interviews with physicians were held in their offices and took approximately thirty minutes (except for three generous physicians who took their time and interviewed back, deeply curious and investing a lot of dialogic energy into the interview).

Medical interviews were conducted with twelve physicians in private sector medicine, of which five also work in the public sector. Four interviews were done with childbirth educators who live in the north and work with women who use private sector medicine, and five interviews with midwives who live in the south and work with women who combine public sector medicine with lowcost private care and midwifery. Seven interviews took place at the O'Horán with physicians, residents and nurses, and five interviews with physicians who work in lowcost private care. All of the last group works in the center of the city around the market.

As mentioned above, the women interviewed were selected through an ongoing search for difference, for people who represented new aspects of life in the city. The interviews took place in thirty eight different colonies. According to the ranking that City Hall makes of each colony in terms of socio-economic status, eight of the interviews were

Table 1: Characteristics of Women Interviewed

Employment			
Professional, Business, Academic	48%		
Fulltime Home-makers	29%		
Service or Retail Sectors	22%		
Education: (highest level entered)			
MA or PhD	19%	Secondary School	6%
College	17%	Primary School	10%
High School	19%		
Age			
under 19:	6%	30 - 39	27% over 50 6%
20 - 29:	50%	40 - 49	10%
Location of birth			
Private clinics*:	46%	IMSS - Seguro Social	38%
Servicios de Salud	7%	Lowcost private clinics	9%
Number of Cesareans			
one cesarean	47%	two cesareans	37%
three cesareans	11%	four cesareans	5%
Geographic origins			
City of Mérida	56%	MX - other State	4%
Yucatan Village	18%	Mexico City	13%
Yucatan Peninsula	8%	Other country	2%
Speaking Maya			
Speak Maya	2%	Do not speak, understand	77%
Understand Maya	8%	Only understand "words"	10%
Families speak, understand or use Maya words:			
None	33%	Yes, close family members	48%
Not asked**	17%	Only distant family members	2%

* 4% of the women who gave birth in private clinics had also given birth in the Seguro Social

** I did not pursue this question to 17% of those interviewed who said they did not speak Maya, and were from places in Mexico where Maya is not spoken.

in "Residential" neighborhoods, eighteen were in "Medium" neighborhoods and twenty took place in "Popular" neighborhoods (see explanation of these terms on p.13, 14). As a general tendency, I was referred to people who lived in the more privileged areas of the "medium" and "popular" neighborhoods. In two cases, however, I interviewed women in "popular" neighborhoods who lived in extreme poverty.

The other areas of difference consciously sought out were in terms of employment, education, age, location of birth, and number of cesareans (see Table 1: Characteristics of Women Interviewed). Women were also asked about family origins and whether or not the women themselves or their families could speak or use Maya. The question about speaking Maya is a carefully negotiated one. Women from the opposite ends of the socio-economic and geographic spectrums were in the category of "understanding" or "using words", the language is evenly distributed across the spectrum of difference and education. For women in the south, the answer could or could not be prejudicial and had to be answered according to their perception of what I wanted to hear. Am I one of the foreigners who visits Mérida with a fascination for the Maya language, or does my social placement in Mérida mean that I will interpret a positive answer as a definition of ethnic identity and corresponding social placement? For wealthy, educated women, some of the enthusiastic answers that they (or their families) understood "a little Maya" were statements of cultural acquisition. One woman learned from her Maya nanny, another had taken Maya courses as part of her anthropological training. One of them thought hard until she could recall a remote grandmother who knew a little Maya, a way of marking her own "authenticity" as a Yucatecan. While women can be put into these categories for

the purpose of illustrating difference, it is important to remember that the way in which each individual manages their particular constellation of these factors was unique.

Analysis

All interviews were transcribed in Spanish, and subsequently coded with ATLAS/ti, a text analysis software package developed around the "grounded theory" of Glaser and Strauss (1967) with the idea that theory and patterns emerge out of interaction with the research data rather than data materializing full-grown from a previously designed hypothesis. The basic unit which holds all the important elements of ATLAS/ti is called a "Hermeneutic Unit." For research purposes, a "hermeneutic circle" is a process by which both the original thinking about a question and the emerging results (in terms of patterns or conclusions) are under constant revision throughout the research, itself conceived of as a systematic, multi-stage, inductive process. This is an open circular pattern of "deepening, refuting, complexifying the concepts through the progressive iterations of collecting data, processing, analyzing--or orbits through the hermeneutic circle." This continues until "you are satisfied, run out of funding, or have a deadline to meet."[11] ATLAS/ti is designed to facilitate this iterative process by the process in which one makes codes and refines them through writing memos, creating queries about both the interview texts and the emerging patterns, and making the codes again. Much of the

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[11] ATLAS/ti has a listserv in which researchers discuss methodological issues, panics over software glitches, or comments on the "topic of the day." I owe my ideas on this matter to a discussion which resulted from Mary F. Annese's (MPA Minerva & Associates) question to the listserv about the nature of qualitative methodology and how one "does" it and "thinks it" with ATLAS/ti. One of the people who contributed with particularly well-formulated ideas, and whom I quote above, is David Smilde of the University of Chicago, currently working at the Universidad Central de Venezuela.

coding I began with does not even appear in this dissertation. As I read and reread, coded and re-named codes, and coded again, the patterns that became chapters in this dissertation grew out of the elements that appeared as key in how women and physicians talked about the cesareans.

Each interview also was in some ways a response to the dialogic moment which both shaped the interview and was formed out of the interviews which preceded it. In this way the original research question can flow, gathering new shapes and abandoning those which turn out to be irrelevant. Rather than a search for a certain number of representative responses, the interview process was a search for new ideas, for common threads of thinking, and even for new questions.

Out of respect for the written format of dissertations, and out of concern for readability, I condense the words of the transcriptions into the textual quotes presented here. The murmurs, silences, affirmations, hesitations, and false starts that create a dialogic space for two people to interact have been leveled into the kind of quotes that I hope the physicians and women I interviewed will feel more comfortable reading as text (Finnegan 1995). My apologies to those of you, who reading your own words, consider it otherwise.

Order of the Dissertation

The first and second chapters of this dissertation are about settings. The first chapter, in addition to explaining the logic of the dissertation, also includes a description of research design and methodology for this study and what is important to understand about the social landscape of Mérida. Chapter Two covers some of the meta-narratives

that are most often told about cesareans – in this case how medical and social science research addresses the issue of cesareans. The physical setting, the methodological setting in terms of intellectual framing and the design of the research, and the setting of meta-narratives of the cesarean are all a part of the framing and context within which the following chapters should be read.

The second chapter begins with the narrative that is the most familiar to those who study cesarean in terms of cosmopolitan medicine and epidemiology. The research for this dissertation comes out of the questions that epidemiology raises, and explores the meanings of the distribution patterns in the lives of the people that make up the numbers. Epidemiological background is important to understand the social stratification so inherent in cesareans, tracing patterns that go beyond the physiological patterns of biological childbirth. A look at the statistics and distribution levels is the narrative most often told about cesareans, but it highlights difference and comparisons between countries and how they organize their medical care. However, the meanings in everyday people's lives are also informed by the meta-narratives that make up the epidemiological questions in the first place. This way of looking at cesareans also requires that we think about structures of power and how people relate to them. While it is difficult to find resistance to cesareans in individual narratives framed in terms of the medical encounter, there is a general critique and discomfort about cesareans that permeates conversations and stories about cesareans.

In the following three chapters I make the argument that the resistance to cesareans does not take place at the level of protest, or newspaper articles, or health movements, or activism, or ways to change health policies, but at the level of negotiating meaning in

motherhood and the social bodies that make up the landscape of Mérida. I argue that due to the way the economy is organized, familial and friendship networks are crucial to survival, and the creation and maintenance of those social bodies is an important part of the work of mothers. Demonstrating competence in this arena underlies much of the narrative structure that people use to tell about their cesareans. I examine this process through three ways that women talk about cesareans in non-medical settings, in this way negotiating some of the terms of the larger social bodies that are brought into becoming at childbirth.

The third chapter addresses two of the ways that a mother who has gone through a cesarean negotiates her preparation to enter the world of motherhood. Conversations about what is a good, worthy mother, and struggles over how to achieve it take place between women, and often about other women. These conversations transcend social class and ethnicity, although the content and shape of the stories differs. Having a cesarean puts two necessary conditions for good mothering under suspicion, both of which seemed important enough to be addressed almost repeatedly in the narratives. The first is about a woman's strength and ability to suffer physical and emotional pain and still triumph. Popular knowledge about cesareans names surgical birth as a way to give birth without pain, and condemns the women who want them as afraid to suffer. Women who have had cesareans determinedly assert through their narratives that the cesarean is painful and requires a long recovery period. The second is about the much higher resources spent on a woman with a cesarean, she has taken up more social and economic space. She requires more physical help for a longer period of time to recover, and especially in private care, many more financial resources. This aspect of the cesarean

appears to be positive rather than morally loaded as the previous one. By including the social and financial resources expended on her behalf in her narrative, she demonstrates that she has the social and economic support of her social body, the people committed to her and her future family. The negotiation of pain, and the demonstration of social and financial resources are told in distinctive ways by people in different positions in the social landscape, but the general patterns are deeply embedded in the telling of a cesarean.

The fourth chapter looks at how the mother-baby body is imagined and defined. At the smallest segment of what can be considered a social body is the body of the pregnant mother, a unit of two, or two that form one unit. There is a dys-synchrony between the medical ideology that leads to cesareans and the way many people imagine childbirth. Many people think of an active fetus who contributes strength and force to labor, but the medical image of the fetus is an inactive, still entity in childbirth. This still fetus is imagined to be potentially damaged through birth in various ways: brain damage; aesthetics, and by undue stress - reflecting a shift in ideas about physical exertion and what kind of mental and physical environments and activities are significant for the baby's future.

The fifth chapter deals with sexuality. Underlying my thesis questions is a curiosity about how women/gender relations are portrayed, acted out, represented, lived through the telescope of medicine and childbirth. The move from vaginal birth to abdominal birth carries with it changing images of what women want or expect from their bodies. Cesarean narratives must be understood within the larger cultural conversations, not always harmonious at all, over appropriate gendered, mothered bodies and into the

aesthetics of being sexual. That this changes according to social position in society should not come as any surprise, but that it should be daily inscribed on the bodies of women in the shape of their cesareans is. Poor women who tend to come from the rural areas and be more indigenous are much more likely to get a vertical cut down their abdomen in the hospital which prides itself on efficiency. Wealthy women who go for private care are told over and over that their cesarean scars are practically invisible, that they are buried in their pubic hair, that they can wear bikinis comfortably. In this patterning of surgical cutting, physicians inscribe their ideas about which bodies are to be attractive and desirable, and to whom they think it doesn't (or consider that it shouldn't) matter. The final point is how women use their narratives about cesarean to negotiate the terms of their return to a sexual intimacy in different ways.

Through these chapters, this study demonstrates that women choose to use narratives about the cesarean to enter into a discussion/conversation with several broader cultural narratives about what it means to: contest or demonstrate competence in the moral and authoritative domains of being a good mother; be a mothered body in pregnancy, and to negotiate the sexuality of childbirth in the many, often over-lapping spaces of Mérida society.

CHAPTER TWO
THE NARRATIVES IN THE NUMBERS

The cesarean as childbirth has been a subject of many kinds of narratives for a long time. Back in the 1860s, when doing cesareans meant a great deal of suffering, and high probability of death[1], but were also seen sometimes as the only possible avenue to save a woman's life, one physician commented, "To my knowledge, there has been no subject connected with medicine which has created more bitterness of feeling and animosity" (Radford 1865:1, quoted in Churchill 1997:22). Part of religious debates over baptism of infants and women's suffering[2], stories of heros, gods and kings "not of women born" (Blumenfeld-Kosinski 1990), cesareans are a means of birth that has been particularly fraught with gendered ethical and moral issues for a long time. The editor of the British Medical Journal recently published an article on cesarean rates in Latin America, accompanied by commentaries and a whole sequence of letters available on the web. The editorial that accompanied the article was called, "Politically incorrect surgery," and pointed out how the cesarean is one of the most politically fraught of operations, competing only with lobotomy and circumcision.

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[1] In 1888 Harris reported that the recovery rate for women performing the operation on themselves was 66 per cent compared to a rate of 37.5 per cent for American physicians up to 1888, and 14 per cent for their British counterparts (Harris 1888 cited in Churchill 1997:31).

[2] Cesareans were a part of religious stories as well, a papal edict published in 1614 required that should a pregnant woman die, her child should be removed and baptized.

When we think of cesarean stories, or even the meta-narratives about cesareans, it is easier to think of literature, legends, mythology or even the religious interpretive frames. Cesarean narratives show up in Shakespeare (Macbeth), Hemingway (A Farewell to Arms, Indian Camp. See Wolter 1993, de Costa 1988), Greek mythology (births of Adonis and Aesculapius), Eastern mythology (births of Brahma and Buddha) (see Blumenfeld- Kosinski 1990, Churchill 1997, Sewell 1993, Trolle 1982 for more examples). Cesareans done postmortem to save a child whose mother had died are recorded in Egypt (3000 B.C.) and India (1500 B.C.) (Churchill 1997:2, Trolle 1982:15). Jewish laws dating from 140 B.C. are referred to which stated that women who gave birth by cesarean did not have to observe the days of purification that were needed for those who went through vaginal delivery (Bishop 1960, cited in Churchill 1997:2, Trolle 1982:17). A successful cesarean carried out in Uganda in 1879 is often cited because the techniques of the operation were obviously well developed (Sewell 1998:4, Trolle 1982:30). The narrative from Switzerland of the pig farmer who gave his wife a successful cesarean in 1500 seems to circulate pretty consistently with those who write histories of the cesarean (Trolle 1982:29). I first heard it from Dr. Urzaiz during a presentation, "History of Obstetrics in Yucatan", for a group of physcians at the Medical School of the Universidad Autónoma de Yucatán. There is also a wide variety of genres available for personal cesarean stories, both in academic work coming out of the women's health movement in the United States and a corresponding interest in birth stories in social science and literature (for examples, see: Oakley and Richards 1990, Coslett 1991, Pollack 1999). Cesarean stories also circulate in among midwives, childbirth activists and on web pages.

In medical and social science literature, narratives about cesareans are more frequently told with numbers. The nature of numbers is comparative, to seek out difference and similarity and provide information that guides health policy decisions. When cesarean rates are counted, or made important in reports from hospitals on their activities it is because these numbers are sought out to tell a narrative. To decipher what the numbers mean to the people reading them is to examine the narratives in how obstetrical services are represented and debates surrounding their use.

To tell some of these epidemiological narratives about cesareans and understand how the cesarean rates are variably reported on and discussed within the context of Mexico, it is important to first understand something about the structure of Mexico's health system and the ways that the different health systems are organized. Following is a brief description of each sector and a description of the difficulty of reading cesarean rates nationally for Mexico and for the state of Yucatán. It is also important to remember that the three sectors named below do not include alternative kind of care, including self care. In considering the ethnographic space of childbirth, this is particularly important because of the women who still choose to give birth at home or with midwives.

Mexico's Health Systems

Secretaría de Salud (Ministry of Health)

Health Services are labeled by the population they are supposed to cover, and the Secretaría de Salud covers the *población abierta* (open population), meaning all persons in Mexican society who do not have access to the other health care systems. This program is completely subsidized and run by the government and is called the *Secretaría*

de Salud, broadly known as *Servicios de Salud*, or still by SSA (*Secretaría de Salubridad y Asistencia*, an old name). Sometimes the statistics from this category also include data from: IMSS Solidaridad (which used to be known as IMSS-Coplamar and which provides medical services in return for community service); the Red Cross; and INI (*Instituto Nacional Indigenista*/National Indian Institute): all health systems designed in one way or another to meet the health needs of the informal sector. The Secretaría de Salud represents the most basic level of care for the most marginalized portion of the Mexican population, and has the least amount of resources, but it is also the government sponsored health care system and as such has the responsibility for gathering and publishing information from all sectors of the health system.

Instituto Mexicano de Seguro Social (Mexican Institute of Social Security)

This health system is available for all members of the population with jobs in the formal sector, referred to as *derecho habientes* (with rights). This health service is governmentally run, but depends on percentages taken from all salaried employees, whether that is in the form of contributions from employers or taken from the paychecks of employees themselves. (This system includes primarily IMSS, *Instituto Mexicano de Seguro Social*, and ISSSTE, *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* which has seventy major hospitals in the country (Fajardo Ortiz 1996:340). Many times the data for PEMEX *Servicios Médicos de Petróleos Mexicanos* (Oil), SDN *Secretaría de la Defensa Nacional* (the military) will be included as well because they are government provided health care systems to particular populations. IMSS is known for having the most sophisticated technology in their tertiary hospitals,

often surpassing what is available in the private sector. In 1996 IMSS had two hundred fifty general hospitals, forty high speciality concentrated centers and ten National Medical Centers (Fajardo Ortiz 1996:339). The T-1 in Mérida, one of the two primary IMSS hospitals, recently was renamed as one of these National Medical Centers, *Centro Nacional Dr. Ignacio Garcia Tellez*. They are also known, however, for long waits, for staff that are tired and stressed, and poor quality of care. Wealthy women said they would not consider IMSS a place to give birth, regardless of their rights as employees. Other women, with fewer resources, spent limited funds to supplement the care at IMSS with a more economical version of private care through the obstetricians who have offices near the marketplace or with midwives. In this way, they double-check to make sure that the care and the information they are given, is sufficient and accurate.

Private Medicine

The first two governmental systems just mentioned, the Ministry of Health (Secretaria de Salud), and the Social Security system (IMSS) are often counterposed to a third with the simple dichotomy "public" (provided by the government) and "private" medical services provided either by industry or private sector. Another way to make this distinction is to refer to the governmental services as "institutional" medicine, differentiating it in this way from "private medicine." This does not mean that private medicine does not have highly developed institutions, but rather refers to the role of the client in how their care is decided on. Governmental medicine is seen as institutionally run and designed around the "Norma Mexicana" and nationally designed health policies. Private care is designed around the client's need and ability to pay.

Figure 2-1: Cesarean Rate Percentages in The Public And Private Sector in The Different States of Mexico

Private medicine, however, is not monolithic. There are many levels, some of them much more institutionalized than others. In Yucatán two words in popular usage refer to private care: "*privada*" and "*particular*." The first refers primarily to the most elite form of obstretrical/gynecological care: corporate care with doctors who pool resources and work in specific clinics. "Particular" is used more broadly, referring to elite private care, as well as to obstetricians in smaller clinics or with offices in the market accessible to the rural and suburban populations. Private care is the most responsive to patient needs for safety and comfort. Physicians and health policy makers in the public sector refer to private care as less professional and research-based, less concerned with the "science" of medicine and too responsive to individual needs. Private medical care provides the best service, loyalty and personal attention, but government hospitals are still considered to have the most up-to-date and state of the art equipment and technology.

Cesarean Rates in Mexico and Yucatán

A search for information on cesarean percentages in Mexico initially is a fairly straightforward task. Internet sites for SSA provide national data per state and for private care. Any more detailed information, on a city-wide level is difficult to obtain. Consulting official formats reveals no data except for state-wide information, with the data for the different sectors of the health system averaged together. Even with special research permits, it was not possible to be given this information through any official venues such as Servicios de Salud or INEGI - confidentiality in these matters is promised to the institutions. This illustrates how cesareans rates are political and as such have their own track records in Mexico's official information system.

Initially, the health system began gathering careful information about the cesarean in 1993. Shortly after that, it became obvious that Mexico was one of the countries with the highest rates in the world, and both the means of gathering the information and the forms of reporting became much more precise and obfuscating in the quantity of detail and sub-categories. When an attempt is made to update information on rates through INEGI and Servicios de Salud web sites which used to carry this information in very accessible formats, the information is now diffused through the creation of many different categories. On one hand, in one case there was a shift from using "cesarean" to using "surgical intervention" which includes the use of forceps or vacuum extraction in vaginal births. On the other hand, the information is diffused through different sectors of Mexico's health system, rather than through the three broad categories they generally use to report health data. For Servicios de Salud, the information is now available by institution, (DDF, SDN, SM, PEMEX, ISSSTE, IMSS, Población Abierta), all managed in so many different ways, with differing sizes of populations, that it is difficult to draw larger conclusions on the data available. In other cases, the information is simply no longer available. For example, in "Atención Obstétrica[3]," where the numbers of cesarean used to be for Servicios de Salud the current information is now simply about total number of births compared to total number of live births per state, and number of women attended[4].

Data is also often gathered under pressure from questionable sources. For example, in Yucatán the cesarean rates for the private sector show a slow steady increment from

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3 http://www.ssa.gob.mx/prop/estadis.

4 Fuente: DGEI, Boletín de Información Estadística No. 17, Vol. I, 1997.

51.2% in 1992 to 57.6% in 1996 according to a local Secretaria de Salud report. Of the eight hospitals and clinics which are included in the report, only six submitted information. One of them reports a cesarean rate of 95.7% in 1992, 131.3% in 1993, and 183.3% in 1994 and 135% in 1996[5]. The report simply states that *lo cual no es explicable* (this can not be explained), but the final rates for the region reflect that anyway. I do not know how many private hospitals and clinics are in the state of Yucatán, but I have seen a list that INEGI uses to compile cesarean rates that has twenty six private clinics and hospitals only in the city of Mérida. The information, however, may in the end not be so far off. I only know the rates for two private hospitals in Mérida. The Clinica Mérida reported a rate of 57% in 1996[6], and Santa Elena had a rate of 64% in 1999 (Mendez Arceo 1999).

In the public sector, Mexico's average number of cesareans is only 24%[7] compared to 48%[8] for private sector. When not averaged into national rates, some private hospitals have cesarean rates of over 70% (see Table 4, Castillo 1997). However, these numbers showing huge disparities on the map of Mexico above (see Figure 2-1: Cesarean Rate Percentages in The Public and Private Sector in the Different States of Mexico) must be

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[5] It would appear that instead of dividing the number of cesareans by the total number of births, the number of cesareans was divided against the number of vaginal births. The corrected rates, if that were true, would be 49%, 57%, 65% and 57% respectively.

[6] "Nacimientos y Cesáreas en el Sector Privado. Yucatán 1992-1996. Secretaria de Salud. Working report.

[7] Estadísticas del Sistema Nacional de Salud. Capítulo: Secretaría de Salud Boletín Mensual del Sistema de Información en Salud para Población Abierta (SISPA). Salud Perinatal, Periodo: Octubre de 1998.

[8] "Atención Obstétrica según Tipo, por Entidad Federativa." Estadísticas del Sistema Nacional de Salud, Unidades Médicas Privadas. Instituto Nacional de Estadística, Geografía e Informática (INEGI), 1998.

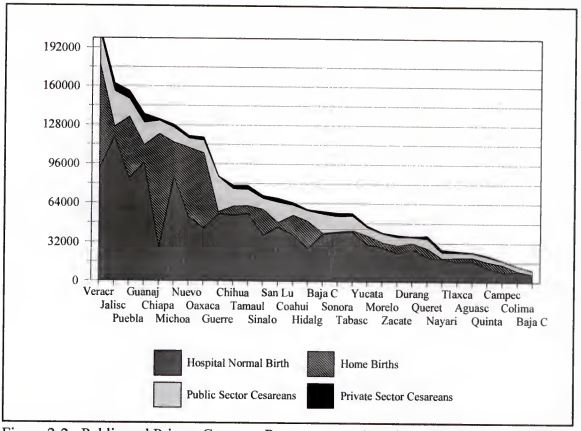

Figure 2-2: Public and Private Cesarean Rates compared to Normal Home and Hospital Birth. INEGI 1996, 1998. SISPA 1998.

read within the larger context of where birth takes place in Mexico and how many people have access to the private clinics which have the high cesarean percentages[9]. In Figure 2-2: Public and Private Cesarean Rates compared to Normal Home and Hospital Birth[10], shows total numbers of births in the population, rather than percentages. This makes it clear that the actual numbers of cesareans done in elite hospitals is far smaller than the children born with midwives, far less than the natural births in all of the hospitals, or even

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[9] "Intervenciones Quirúrgicas Realizadas en establecimientos particulares por entidad federativa y tipo de intervención, según número de camas censables." (1996) Cuadro 9.9; y Información Estadística del Sector Salud y Seguridad Social, Cuaderno 14, 316-321, INEGI 1998.

[10] For total population, INEGI (1996) "Resultados Definitivos de los Tabulados Básicos. Estados Unidos Mexicanos. Based on the "Conteo de Población y Vivienda, 1995. For the other data, see Footnote 7: SISPA 1998, Footnote 8: INEGI 1998, and Footnote 10, INEGI 1998.

than the cesareans done in the public sector. The part of Mexican privileged society that is getting the 60-70% cesarean rates is a very small segment of the entire population.

Midwifery attended birth has been dropping dramatically in the last 30 years, with an especially deep decline in the last decade. Please see Figure 2-3: Midwifery Attended Birth Between 1985 and 1997 in Eight Villages of Yucatán.[11] This decline in normal births being attended by midwives does not reflect the increase of normal birth that should logically then happen in hospitals. On the contrary, there is a steadily increasing number of cesareans done.

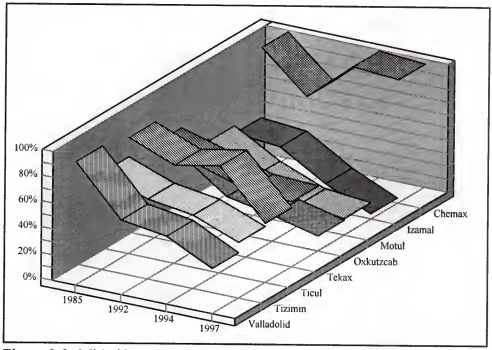

Figure 2-3: Midwifery attended birth between 1985 and 1997 in eight villages in Yucatan.

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[11] "Nacidos vivos registrados por entidad federativa y municipio de nacimiento según lugar donde se atendió el parto." Taes17 hoja 001, INEGI, 1985, 1992, 1994. "Nacimientos registrados por municipio de ocurrencia, según lugar donde fue atendido el parto." Cuadro 1.9. Fuente: Dirección General de Estadística. Dirección de Estadísticas Demográficas y Sociales. Dirección Regional Sureste. 1997.

Epidemiological Narratives

The following section reports on some of the similarities and differences found in cesarean rates and the narratives expressed through the findings. My goal is not to draw conclusions as to the reliability or validity of these rates, but rather, what kinds of patterns are embedded in them, and how the formulation of the statistics should be considered as struggles over representation as well. The kinds of debates that most rely most on statistics in the cesarean are issues such as international patterns, rates of change, debates over which countries or regions have the highest rates, the high costs of cesareans, safety, the illogic of the social distribution of risk, and issues of when the cesarean becomes a luxury commodity and what role women's choices can play when emergency obstetrics becomes routine. It is artificial to attempt to separate out these different elements in the representations of high rates of cesarean because they overlap in so many ways, but I do so in the effort to make the different narratives clear.

International Patterns

The first narrative framing many of these debates is about the compelling different patterns in the rise of rates in distinct parts of the world, a phenomena that has provoked interest in comparing public health policies, medical practices and cultural contexts in which obstetrics develops. The World Health Organization recommended that cesarean rates not exceed 10-15% and national rates are often compared to that. (Good outcomes have been reported with lower percentages in other parts of the world (Bood 1990, MacFarlane 1993, Stembera 1995, Ziadeh & Sunna 1995). Mexico's own "Norma Oficial," put out by the Servicios de Salud states as an objective:

> 5.4.1.6. All obstetrical medical units should have the necessary guidelines for indicating cesareans. The actual recommendations are that second level hospitals have rates of 15% and 20% for tertiary hospitals in proportion to the total number of births. All units of medical attention should make the effort to meet these rates. (Norma Oficial Mexicana, Secretaría de Salud, 1995)

In the mid-80s and early 90s, Notzon reported the following percentages in the following countries. In Czechoslovakia, Japan and the Netherlands, levels of cesarean were very low, around 7% (Notzon 1990). Sweden, Spain, Norway, New Zealand, England and Wales, and Hungary had rates between 10-12%. Countries such as Denmark, Greece, Italy, Portugal, Australia, Bavaria and Scotland had rates that range between 13-16% (Notzon 1990:3287). Most articles on comparative rates between countries focus on Europe, United States and Canada and Japan, the countries considered part of the industrialized world in the most narrow definition. (In the last five years, more attention is being paid to countries such as India and the Middle East. In the following section, I focus on the information available in Latin America).

Ferraz quotes the 1995 CLAP (*Centro Latino Americano de Perinatología*) study of cesareans in 17 countries. This study was designed to reduce cesareans and looked for a baseline of information between 1988-1992. She reports some of the large variation in cesarean rates across Latin America evident in the study. Part of her narrative, however, is to contextualize this information in the larger patterns of maternal mortality. In this way she requires us to question what low cesarean rates may mean in different contexts (see Table 2: Epidemiology of the Cesarean in Latin America, below).

Table 2: Epidemiology of Cesarean in Latin America		
% of Cesareans	Country	Maternal Mortality/1000
Low Cesarean rate percentages and high maternal mortality		
10%	Honduras	22
15%	Bolivia	42
Low Cesarean rate percentages and medium maternal mortality		
6%	Trinidad and Tobago	6.1
Medium Cesarean rate percentages and low maternal mortality		
17%	Cuba	3.2
20%	Costa Rica	3.5
High Cesarean rate percentages and medium maternal mortality		
35%	Brazil	8.5
33%	Ecuador	13
40%	Paraguay	11.4
High Cesarean rate percentages and low maternal mortality		
30%	Chile	3.6

Source: Ferraz 1997:15, PAHO, Mexico D.F.

Belizan's recent article on the distribution of cesareans in Latin America also is a comparative study, with a focus on the socio-economics of the distribution (see Table 3: Cesarean Rates (%) in Latin America, next page). (The table in the article also includes information on population, number of physicians, urban population, mortality statistics and maternal and infant mortality rates.) In his discussion, he mentions all the difficulties of the necessity of reporting ambiguities very conservatively, and the disparity of the sources themselves.

Table 3: Cesarean Rates (%) in Latin America				
Country	Year	All Hospitals	Public	Private
Haiti	1995	8.2%		
Bolivia	1994	15.0%		
Peru	1997		12.0%	
Paraguay	1997	20.7%	17.0%	41.0%
El Salvador	1996	22.1%	20-22.9%	
Colombia	1997		32.5%	58.6%
Panama	1996	20.5%	20-21.1%	
Ecuador	1996	26.3%	18.5%	
Costa Rica	1993	20.8%	20.8%	
Venezuela	1995	21.0%		
Uruguay	1996	21.9%		
Cuba	1997	23.0%	27.4%	
Mexico	1996,95*	31.3%	27.4%	51.8%
Argentina	1996,97	25.4%	15.4-20.9%	35.8-45%
Dom. Republic	1996	25.9%		
Brazil	1996,94	32.0%	20.2%	35.9%
Chile	1997,94	40.0%	28.8%	59.0%
* When two years are given, the first corresponds to national rate and the second to the institutional rates.				

Belizan 1999

Belizan's study amply illustrates how difficult it is to draw conclusions about national data in Latin America (1999:1397-1399). Mexico is one of the countries that does not have a national rate because the rates are gathered from the different sectors which do not

add up to 100%. Belizan's study shows Mexico's public and social security hospitals at 27.4%, private hospitals at 51.8% (taken from the data on Table 4), and all hospitals at 31.3%. They explain how they arrived at these numbers:

> Mexico had an estimated 2,338,000 deliveries in 1996, of which 84% were institutional (1,964,000); 1,520,200 were well documented as public sector births, with a caesarean section rate of 27.4% (416,000). The remaining 443,600 births are estimated to correspond to the private sector, which had a caesarean section rate of 59% (261,700). The estimated number of caesarean sections in 1996 was 677,800. (Belizan et al 1999[12])

Since the figure of 84% was taken from a column called "Institutional and Skilled attendant deliveries," it raises the question as to where the midwife attended births were counted. While midwife attended births have dropped sharply since the beginning of the 1990s when they were estimated at over 40%, debates about current rates usually put them about 25% (Cao Romero, 2000). Were midwife-attended birth part of the public sector total births? That would explain, perhaps, how the public sector can report such low rates when all the hospitals in the system average 35-45%.

Rate of Change

Another way of writing about the cesarean is in reference to the rate of change. Rates of change are rapid and look impressive, raising important questions about what has changed in obstetrical services and what people look for in childbirth. Rates for New Zealand mentioned above changed dramatically by 1994/95, rising from 9.6% in 83/84 to 15.3% in 1994/95 (Bulgar et al 1998). In Chile, cesarean rates rose from 27.7 % in 1986

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[12] Provided in "Further details of data sources" which corresponds to the original article by Belizan et al, at http://bmj.com/cgi/content/full/319/7222/1397/DC1.

to 37.2% in 1994 and 40% in 1997. Chile shows the same difference between public and private rates as Mexico, with 28.8% of the women in the National Health Fund getting cesarean births, and 59% of those with private insurance (Murray and Pradenas 1997). A comparison of Tables 2 and 3 shows an increase in cesareans in almost all Latin American countries, although it is difficult to compare given that it is not clear which populations and health service systems are represented in the data provided by Ferraz. In Mexico's IMSS sector, the rates rose 11% from 1985 to 1994, from 21% to 32% (Velasco and Navarrete 1995). Although the period is not quite comparable, rates for the Secretaría de Salud in Mexico climbed from 11% in 1990 to 19.4% in 1997[13].

How High Is Too High? What Is the Highest?

The other question examined in these cesarean is how high? Since most comparative studies have been done between European countries, United States and Japan, the struggle has been over what rates are too high? (e.g. MacFarlane and Chamberlain 1993, Francome and Savage 1993). Rates in United States were among some of the highest, reaching an all-time high around 25% in 1988. Currently those rates are around 21% (Curtin 1997) with most of the reduction attributed to an increase in vaginal birth after cesareans.

The Pan American Health Organization (PAHO) study mentioned above put Mexico at 29.1% in 1985 (Coe & Hanft citing Belitzky et al, 1985), and that number was still only 27.4% for the public sector in Belizan's 1999 study. It is unclear if the private sector was

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13 "Porcentajes de Cesáreas, Nacimientos atendidos y bajo peso." Source: Servicios de Salud, DGEI, SISPA. Http://cenids.ssa.gob.mx/dsgr/indicad/bcn/porcbcn.htm

included in the first PAHO study, and the current rate of 48% for the private sector puts Mexico among the competitors for highest numbers.

Brazil has been famous in all comparisons of cesarean rates since the studies of Janowitz et al in the 1980s and practically represented Latin America in the international comparisons for a long time. In Belizan's 1999 study the numbers in Brazil no longer lead Latin America (the national average is 32%, the public hospital rate at 20.2% and the private sector at 35.9%). If this is actually the case, there is an interesting story in Brazil, because previous statistics showed that rates were approximately 60% in some private hospitals. In the case of some of the private hospitals in the huge metropolitan areas of Sao Paulo and Rio de Janeiro rates have been recorded at over 90% (Pinotti and Pinotti 1994, quoted in Langer, Sloan and Winikoff 1997). Brazil has twice changed health policies to reduce the number of cesareans. In the first case, they began to reimburse physicians at the same rate for both natural birth and cesareans, and found that the rates continued to rise, because cesareans are much more efficient than waiting out a vaginal birth. It was still more efficient and economical to do cesareans if they were paid at the same rate (Tico Times, December 2, 1994[14]). The second change was that previous to 1998 it was illegal to perform sterilizations in Brazil, and many women would ask for a cesarean so that their physicians could do the sterilizations under the cover of the cesarean. Since it is also understood that no woman should have more than three cesareans, this was also a way that women could negotiate lower parity under Catholicism and a country's

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[14] "Monitors Blamed for Cesarean Increase." Tico Times. December 2, 1994. San José, Costa Rica. Quotes a study done on 35,000 Brazilian women from 1978 to 1981. Found that the high number of cesareans did not vary after amounts paid to doctors for cesareans and vaginal births were equalized."

policies oriented around church requirements (Castro 1999).

In Mexico, information on the high rates in private medicine has only become available in more general terms since 1996. Fernández del Castillo shows the rates for nine Mexico D.F. hospitals in 1996-97. (See Table 4: Rates of Cesarean in Nine Mexico City Hospitals).

Table 4: Rates of Cesarean in Nine Mexico City Hospitals

Mexico D.F. Hospital	Cesarean Rate
Hospital de Mexico	34.5%
Hospital Santa Teresa	53.3%
Hospital Angeles	62.7%
Hospital ABC	44.5%
Hospital Español	61.9%
Hospital Santa Elena	68.1%
Hospital Metropolitano	78.8%
Hospital Santa Monica	69.1%
Hospital Medica Sur	59.0%
TOTAL	51.8%

Source: Castillo 1997:35

Rates of cesarean in Yucatán also appear to be quite high in comparison with other parts of the world: 48% and 24% respectively, although they are lower than some northern states such as Nuevo Leon (67% and 33%), and Baja California (61% and 25%) (See Figure 2-1). These are similar to a few other countries in Latin American countries, where some national rates exceed 30%, and some private clinics have rates over 80% (Centro

Latinoamericano de Perinatologia y Desarollo Humano 1989, Notzon 1990, Notzon et al 1994, Uribarren & Evangelista 1993).

Expense: The Costs of Cesareans

In terms of cost, cesareans are expensive and require large amounts of resources. A World Bank document shows that $13.4 million was spent on unnecessary cesareans in 1987 (Mello e Souza 1994). In that same year, The Public Citizen Health Research Group estimated that half of the cesareans performed in U.S. were not medically necessary at a cost of 25-100 maternal deaths, 25,000 serious infections, 1.1 million hospital days, and a cost of over $1,000,000,000 (Shearer 1993:58). In 1994, King and Lahiri (1997) quoted a study done by the Health Insurance Association of America to point out that cesarean section raises the cost of a birth by 66% in the United States. Marston Wagner, former director of Maternal Child health for the World Health Organization, speaking at the annual conference for Mexico City childbirth educators at the Hospital Militar said that the numbers of cesareans in Mexico exceeded the rates recommended by the World Health Organization. Mexico's government could save themselves $206 million pesos per year if the rates would be 15%, and if the rates were 10%, the savings would be at $306 million pesos[15]. He was widely quoted in newspapers the next day.[16]

The cost argument used against high cesarean levels by activists and international health agencies is very persuasive: people and insurance agencies pay more for cesareans;

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[15] Invited speaker, "Parto por parteras en el Mundo." January 23, 1997. Annual conference of the Mexican Psico Profilaxis Educators.

[16] "El lucro impide. . ." Excelsior, January 27, 1999

governments spend more in the institutions they create to deal with maternal/child health; recovery time and the use of hospital facilities is extended; and the labor and technology invested in cesareans is much greater than for vaginal birth. Capital, however, is also tied up with time, efficiency and the creation of institutions. Issues of cost would perhaps be more effectively pursued in terms of searching out gain rather than where it is lost. Arguments about the costs of cesareans, the hospital days needed, and the unnecessary use of technology are a key element of activist work to combat the high cesarean levels.

Safety: Where Can it Be Found?

A fourth way of talking about the cesarean are struggles over what is safer for mothers and children. While the cesarean is generally considered, "safer than ever before," epidemiologists have shown that there is no significant correlation between national cesarean rates and perinatal mortality and most countries with cesarean rates lower than that of U.S. also have infant mortality rates that are lower also (O'Driscoll and Foley 1993, Notzon 1990:3289). A 1984 study conducted in Mexico City shows that babies of normal birth weight delivered by cesarean were 2.5 times more likely to die in the early neonatal period than those born vaginally (Bobadilla & Walker 1991). Castro's current work on evaluating some of the impact of high cesarean in both Brazil and Mexico has confirmed Bobadilla's correlation between cesareans and neonatal death due to respiratory complications, and concludes that "c-sections have an enormous impact on mortality and on the quality of life in Mexico" (Castro 1998). Maternal mortality rate is estimated to be 2-11 times greater after cesarean birth, and morbidity is 5-10 times higher primarily due to

the higher rate of postpartum infections (Shearer 1993). Langer, Sloan and Winikoff report that among the risks of cesarean must be included the following:

> Cesarean section is one of the two major causes of obstetric infection worldwide (the other being unsafe abortion) and is associated with increased post-surgical infectious morbidity. There is strong evidence showing the deleterious effects of cesareans on neonatal health: iatrogenic prematurity, lower frequency of successful breast feeding and respiratory distress are its major negative consequences. It also contributed to longer hospital stays, overcrowding and misuse of health care personnel and resources. (Langer, Sloan and Winikoff 1997:2)

An article in the Mexican Journal of Obstetrics and Gynecology laments the high rates of cesarean for the following reasons: "more risk of bleeding and infection than a normal birth, the negative influence on the future reproductive capacities of the patient, and it generates many more demands on the institution" (Uribarren and Evangelista 1993:169).

Increasingly, the issue of relative safety is being raised. Cesareans are less safe in certain populations than in others. Cesareans done under good conditions with adequate follow-up are safer than cesareans done under emergency conditions in poorly equipped and staffed locations.

Social Distribution of Risk

Aggregate statistics quoted for regions or countries often mask the increased risk for socioeconomically disadvantaged populations (Sakala 1993). Both medical and social research indicates increasing concern over the institutional costs and the health risks involved for mothers and infants, especially among poorer women who have less access to postpartum care (Bood 1990, Sakala 1993, Shearer 1993, Uribarren & Evangelista 1993).

An Ecuadorian doctor is quoted as saying that this whole problem is very complex and difficult:

> There is abuse of cesareans with private patients to prevent any possible risk in childbirth, and in public hospitals, there is also abuse of cesareans and difficult births so that gynecologists/obstetricians in training can get experience. (Bustamante, 1994).

Van Roosmalen and van der Does point out that the relative safety of the cesarean delivery has only been achieved in a very few parts of the world, so the statistics given above are often drawn from studies in privileged populations (Van Roosmalen and van der Does 1995). In some regions the maternal mortality rate can be as high as 1 in 100 operations (Moran & Busch 1987 quoted in Bood 1990). Data from Brazil shows that the mortality rate for women after cesarean is twice as high in the impoverished northeast region of the country as it is in the hospitals of Rio de Janeiro. Statistics can also mask the changes in risk as the number of cesareans increases: high cesarean rates are correlated with a increase of 7-20 times in maternal morbidity, and with a maternal mortality increase of up to 12 times (Mello e Souza 1994:360). A way to understand distribution of privilege in childbirth is Bobadilla and Walker's statement that they found no correspondence between neonatal death due cesareans in the private sector and attribute this to the lack of good care in public hospitals: too many interns and too few specialists.

> Neonatal mortality for babies delivered by cesarean section was considerably higher in public assistance (4.76) than in Social Security hospitals (2.07). Although the cesarean section rate was high (39%) in private hospitals, there were no deaths among babies delivered this way. It is widely recognized that a far higher proportion of births in public assistance than in Social Security hospitals are supervised by interns and residents as opposed to specialists. Social Security hospitals have more than 1.5 times the specialists and far fewer interns than do public assistance hospitals (Bobadilla and Walker 1991).

In an essay in the Lancet, Caroline de Costa paints a contrast between the abuse of cesareans in the industrialized world, and the under-utilization of the cesarean in the developing world. There is no doubt, she says, that in industrialized countries that "the high rate of caesarean sections in most western countries is now regarded as a major public-health problem" (de Costa 1998:1202) and names some of the factors in the abuse of cesareans: the relative safety of the operation leading to complacency, the relative lack of skill of younger obstetricians, fear of litigation, accountability to patients with whom the obstetrician has established a relationship antenatally, and finally concerns about "possible peer disapprobation of poor obstetric outcomes" (p.1203). In contrast, she points out that:

> The low rates in developing countries are complex, but are related mostly to human frailty and greed. Past colonization and exploitation; governments that are despotic, hopelessly incompetent, chronically in debt, or all three; and wars, drought, and famine all contribute to continuing poverty and the social Darwinism that is many women's experience of pregnancy and childbirth. The attitudes to childbearing and contraception (and to the role of women generally) of several of the world's major religions compound the problem. Medical services, if extant, are rationed and such rationing often excludes or diminishes women. (De Costa 1998:1202-1203)

Given that cesareans are much safer, convenient and available to wealthier women with the financial ability to choose the hospitals and physicians that can provide cesareans, the lines between emergency obstetrical services and the cesarean as a luxury commodity become blurred. If women can choose cesareans, why do they do so? To avoid pain? In pursuit of sexually attractive body? (Bastien 1999) This raises uncomfortable questions about both the nature of medicine, and women's rights to select the childbirth services they most desire. It also raises questions about which women can choose, and under what kinds of conditions.

The Modern, Painless Way to Give Birth: Cesarean as a Luxury Commodity.

Over the last few decades in Latin America many women have come to consider cesarean births as a normal, modern, painless and convenient way to give birth (e.g. Barros et al 1991, Janowitz et al 1982, Mello e Souza 1994). According to Balam, a physician and medical researcher in Yucatán, over half of the cesareans in a local public hospital were not medically indicated. He attributes the high rates of cesareans in Mérida to the current cultural and commercial acceptability of surgical birth as a "fashionable and programmable commodity" by women and their physicians (1989:101). A quote from the Ecuadorian VISTAZO article cited above echoes the same sentiments:

> It is not just the physicians who are responsible for the fact that the cesarean is now a best-seller. There are women who specifically prefer them. Many women of the middle and upper classes consider a cesarean much more comfortable than 10 or more hours in painful labor. Cases are even known where women, for very intimate aesthetic reasons (the dilation of the vaginal walls, for example) prefer a cesarean, including for their first birth. In contrast, for women in the lower social sectors, the prospect of a cesarean is objectionable, more money has to be spent and the recovery time is longer. For women such as them, whose need to return to domestic duties is imperative, natural birth is a blessing (Bustamante 1994).

Natural birth, then, is a blessing only when the expense of the cesarean is too high, and when a woman does not have the resources to either hire or rely on family to care of domestic duties through a longer recovery. Cesareans are seen as desirable and purchasable because they can be programmed, because they are supposedly painless, because they are quick. This raises important questions about how the purchasing happens, what kinds of negotiations are made with physicians and is it legitimate for a woman to choose what is supposedly emergency surgery for personal reasons?

Women's Rights to Choose:

To what degree can women make choices about obstetrical care? When the most privileged women in society are apparently choosing cesarean birth and physicians express their frustration with the pressures they feel to perform them against "sound medical practice" raises issues about women's choice, their rights/abilities to make informed decisions, and the validity of those decisions. High rates are represented as being chosen by women because of concern for damage to the pelvic floor, genital damage and concern over future sexual performance (Al-Mufti et al 1996, Bastien 1999, Janowitz et al 1982, Mello e Souza 1994). Thirty one percent of woman obstetricians in United Kingdom would choose cesareans without any medical indication for precisely that reason (Al-Mufti et al 1996). Fairly consistent internationally epidemiological pattern, wealthy women with low risk for childbirth complications receive more cesareans than the poor women presumed to be more at risk (Gould et al 1989; Hurst and Summey 1984:623; Mello e Souza 1994:359). It is unclear as to why this is so. It is interesting to compare the distribution patterns in Chile and Mexico between the public and private sectors, with a study done in the United States on the effect of education and ethnicity on the choice of a VBAC (vaginal birth after delivery). The authors hypothesized that most women, having gone through the unpleasant experience of a cesarean once, would prefer a vaginal birth the second time if given the necessary information to assure them that it would be safe. They quote a study by McClain who found that white mothers were given more counseling about opportunity for VBAC than African-American and Hispanic mothers. They did indeed find that the higher the level of education AND the higher the income level, the more likely that a woman would receive a VBAC. However, African American and

Hispanic women were more likely to get VBACS, even after controlling for education, and Asian mothers were less likely to get them than the white women.

Are wealthy women are preyed on because of their economic resources, or it is because these are the women who wield the most power, pay for their own care and can therefore pressure physicians for what they want? Showalter and Griffin (1999) say the question may need to be asked another way. Rather than seeing women choosing cesareans as a way to avoid childbirth, questions need to be asked about changes in both physiology (birth weights, etc.) and about the physical environments of birth. Belizan and co-authors question the explanation that the rise in cesareans reflects women pressuring their physicians. "In Latin America at least, doctors strongly influence women's decisions; therefore to distinguish between free maternal choice and maternal choice induced by doctors is difficult" (Belizan et al 1999, in "author's reply").

Ballesté and Fernández (1997) raise this issue in the context of reproductive rights. They question whether women have access to the kinds of information they need in order to be able to make adequately informed decisions. How can a woman be a part of the decision-making process about how she wishes to be assisted in childbirth in a context in which the knowledge about childbirth from previous generations has been suppressed, and in which her own feelings and opinions are devalued? They also point out that this question is most generally raised in the context of women who pay the high costs of private care, and therefore feel like they have more choice. How the issue of choice be raised for the rest of women giving birth in society?

In the last two years obstetricians who are protesting the pressure to reduce cesareans are getting a wider audience, writing that the pressure to reduce cesareans has not been

sufficiently evaluated as to the safety consequences of such a policy (Gottlieb 1999:147, Sachs et al 1999) and claiming that the decisions to reduce cesareans to 15% were made on arbitrary information and run by economic considerations[17]. These kinds of articles lean on the "woman's right to choose" kind of representation.

> But the Healthy People 2000 goal of reducing the cesarean-delivery rate to fifteen percent may have a detrimental effect on maternal and infant health. There is no evidence to support this target. Setting a target rate is an authoritarian approach to health care delivery. It implies that women should have no say in their own care. The risks and benefits of various approaches clearly need to be discussed with patients. The National Health Service in the United Kingdom has taken the approach that consumers' choices must be considered; we should do the same (Gottlieb 1999:147).

At the same time, physicians complain that family pressures to do unnecessary cesareans are one of the factors in the high rates, and search for ways to have more control over their own decision-making. One of the ways in which the United States has reduced the cesarean rate has been to encourage vaginal birth after cesareans (commonly known as VBACS). Various articles suggest that in an effort to further reduce cesareans, all repeat elective cesareans be analyzed as a "potentially avoidable elective procedures" (Gregory et al 1998). However, at least half of the women eligible to try labor after a previous cesarean still prefer not to, opting for an elective cesarean instead (Boyers and Gilbert 1998).

In these ways, epidemiological data are designed from, and used to tell a number of over-lapping narratives. The ways in which they overlap cause discomfort for those

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[17] The day after Sachs article appeared in the New England Journal of Medicine, the Diario de Yucatán ran an article, "Putting mothers and babies in danger: Physicians in the U.S. are opposed to the reduction of cesareans" (Diario de Yucatán. Friday, January 8 1999. "Peligrarían madres e hijos: Médicos de EE.UU. se oponen a la reducción de partos por cesárea.")

making decisions about public health, and also for the women and physicians that participate with their own bodies in the construction of the "data." Issues of cost effectiveness and safety have converged in unpredictable ways with issues of the social distribution of risk in childbirth and women's right to choose. This raises many more questions about social relationships, and about how power is created, manipulated and sustained to create such patterns. These stories, however, the views and opinions and particular circumstances of both women and the doctors who attend them are left out of most of these explanations. Biomedical hegemony is a popular term when people write about medicalization and medical control over social processes. It is often used to demonstrate the exertion of power in people's lives over which they have little or no control. Harding points out that victimologies have their limitations. They "create the false impression that women have *only* been victims, that they have never successfully fought back, that women cannot be effective agents on behalf of themselves or others" (Harding 1987:5). But in these circumstances, do women want to be considered actors and agents? How do the physicians feel about it? Under-lying these narratives told with numbers are concerns about how to imagine the power relations that constitute the patterns that make these stories. How do we imagine power and the creativity of people within the structures that they both create and are also constrained by?

Paying Attention to Power

Epidemiological data are "objective" biomedical, demographic and economic measures of pathology. Taussig warns us that such measures are often reified into a "science of things." The objective in this study was to look the other direction at the

relationships that constitute these patterns, and the way people negotiate those relationships through their ideology, through their things and through their bodies. In this sense, what is interesting is when cesareans become the object of social movements, as in the U.S. (ex: Sakala 1993:1183) and Brazil (Mello e Souza 1994:360), or legal battles over the respective rights of fetal and maternal bodies (Jordan and Irwin 1989; Journal of Law 1994; The European Collaborative Study 1994), or when self-help groups form to either prevent or help women deal with their surgically manipulated bodies. It is equally interesting, in contrast, when they do not.

It is an important question. Why is it that there are not social movements oriented around this abuse of cesareans in Mexico? In Mexico's feminist health literature (for example FEM), there are few mentions of the high rates of cesareans. Abuse of cesareans was not mentioned during the Safe Motherhood meetings in Mexico City two years ago when the priority issues were the one in four Mexican women who die of abortions and the extraordinarily high rates of cervical cancer throughout the population. Why discuss an issue of the abuse of technology and medicalization of childbirth when there are pressing needs for better health services in so many sectors of the population? Childbirth educators teach women about birth processes, but there are no support groups for women who have gone through cesareans as there are in parts of the U.S.

Imagining Power in Cesareans in Mérida

Because there is so little individual or group resistance to the high rates of cesareans, and the distribution of the cesareans follows so closely on the lines of privilege and so little along the lines of how cosmopolitan medicine has defined risk, throughout this

research I asked questions about power in society. Work in medical anthropology on power tends towards the frames of "hegemony" or also with Foucault's "biopower." The under-lying question is about how individuals deal with, and are situated in the power structures that somehow define the amorphous shape of the distribution of privilege and power in society.

What does it mean when three out of every four Spanish-speaking, wealthy Yucatecas end up with cesareans? (Urzaiz 1993) Why are almost 50% of the births in the public hospital by cesarean and some Maya-speaking Yucatecas specifically go to midwives to avoid cesareans they have been told are inevitable? Why when I pursued those images that seemed so clear from my master's research, didn't I find women who would put that into words of choice? Why are the rates for postpartum depression rising so much that elite women share information about "patches" and hormones and other ways to combat it? Is it because there are the "patches" and the "hormones" for sale so there are more diagnoses to match it? Is it as the Lamaze childbirth educators say, that women are in depression because they could not give birth normally, they feel a sense of failure? Why don't many women and their physicians resist a form of surgical birth that adds pain and discomfort; runs all the risks of major surgery; locates the greatest abuse within the privileged classes with more resources to resist; and then in addition pay the very real costs in economic terms, and the additional costs of morbidity, pain, infections, longer hospital stays, etc.?

Menéndez proposes that the study of any aspect of cosmopolitan medicine or health must be understood both within the multi-layered form of Mexican institutional medicine, and the social and ethnic patterning of Mexican society. This was portrayed as a moving

away from a "culturalist" approach which was characterized by a focus on "ethnic and cultural affiliations, systems of practice and beliefs, and uses and values in relationship to health/illness" (Foster 1974, cited Menéndez 1985), to a study of the many shapes of what he refers to as allopathic medicine itself, academic, institutional (public and private), and how it is incorporated into everyday practices and treatments at the household level. Menéndez refers to this kind of medicine as the "Hegemonic Medical Model" which "has to be understood within the relationship of hegemony/subalternity that operates between scientific medicine and the other kinds of medical knowledge in society that are subordinated, excluded, transformed or negated by the expansion of cosmopolitan medicine" (Menéndez y Di Pardo, 1996:59). The important part of that definition is that cosmopolitan medical knowledge in society is embedded not only within relations of power and the shapes of institutions, but also in a hegemonic relationship to other co-existing systems of medical knowledge. The value of this approach for a study of cesareans, is the widening of the ethnographic field beyond the actual site of cesareans in the hospital into the other forms of medical knowledge about birth in society. In this case, those other forms of knowledge include the extensive, but subordinated knowledge of the midwiferies that share the social landscape of childbirth; the everyday patterns of conversations between women and their neighbors; and the interaction between women and their physicians. It can also be found in the bodies of the physicians who wonder what has happened to the days when they "diagnosed" in contrast to the present where they feel like slaves to patients who can pay the price for private surgical medicine and assume the authority of a buyer of a commodity.

In Modena's use of Menéndez's medical models, she emphasizes that the efficiency of hegemony in the medical system is not about imposition, around which alternative thinking and action is possible, but in consensus, when the economic and ideological frames of dominant classes are lived as one's own without question. Forms of consensus are renewed daily in the need to survive, to adapt to daily life, as if they were autonomously created by the actors implementing them. They appear in daily life in such a natural way as to appear to come right out of spontaneous thinking (Modena 1990:36).

In Emily Martin's work on the cultural aspects of reproduction she emphasizes that hegemony is both about the shape of science and those who think it, write it into textbooks and teach it in medical schools, and the distribution of this thinking in society. Women are then put into a process of relating to "dominant cultural categories through the medium of conversations about bodily processes." Hegemony is just as much about the shape of the science that forms cosmopolitan medicine, the practitioners who implement the thinking, and the women who think and embody the science and the practice in their own bodies (Martin 1987).

Hegemony: Cesareans as Common Sense

To describe cesareans as a matter of medical hegemony in this way is tempting. Medical language has permeated everyday discourse, with women comfortably referring to their own bodies as *estrechas* (narrow pelvis)[18], to their babies as *productos* (the term used

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[18] Throughout the following chapters I will not always translate the term - it is used in a variety of ways. Medically, *'estrechez'* is used to describe a narrow pelvis. In popular usage, *"estrechez'* can be used by women to refer to a narrow pelvis, a narrow vaginal canal, or narrow hips - all of which are seen to impede a normal birth.

in medical jargon for "baby"), and referring casually to *dilatación* (dilation) and *ráquias* (epidurals). In this research I found it difficult to find spaces of resistance and alternative discourses where women contested the decisions about the cesarean they themselves went through. The respect for a doctor's decision is profound, the unwillingness to question it even more so. One physician said in great frustration that his patients who come to him with a prior cesarean often do not even know why they had a cesarean previously. "Just ASK your doctor why he is going to cut open your abdomen," he advises them, "asking is not the same as arguing with him." Why ask if you don't wonder? If cesarean is what you personally were expecting all along, is what your family expected for you? What if it all just makes sense?

If that were so, medical hegemony in childbirth would be so diffused and commonsensical that there would be no resistance to it. And there are two problems with that. First of all, the further out from the centers of privilege you get in Yucatecan society, the more there is critique about the high rates of cesarean. Midwives protest the abuse of cesareans vigorously as they watch the women they have attended throughout their pregnancies end up with cesareans. Women in southern Mérida, and in villages who go deliberately to midwives – even with the "order" for the cesarean filled out with a date they are to appear in the hospital – do not see the current rates of cesareans as reasonable (Good Maust 1995). The most "domesticated" and "silent" body is that of a woman of privilege with a cesarean. Davis-Floyd points out that it is precisely the women who "participate most fully in a society's hegemonic core value system" who are the "most likely to be empowered by and to succeed within that system" (Davis-Floyd 1996:152). The woman of the upper classes who requests, plans for and schedules her own cesarean

may exist, she is referred to constantly by others as the reason for high cesareans, but in my interviews "she" rarely appeared and through this research I am convinced her shape is much more mythical, more like a mirage. Hegemony is supposed to be about the unquestioning acceptance of elite domination by subaltern groups, yet the further you go from the so-called "center", the more alternative discourses are made possible, the more contestation of the medical system and its inequities. As long as the research can somehow be contained in privileged spaces, it is perhaps easier to find docile bodies and consenting normality. Even if the wealthy woman who plans and makes a cesarean happen is an elusive being, I found many of "her" friends who knew "her" personally, spoke about "her" experience in requesting and insisting on a cesarean and referred to how "she" benefitted and recommends cesarean to all her friends. In this research, however, she stayed in third person.

Secondly, although cesareans are rarely resisted on a personal level, there is a sense of discomfort about how many cesareans there currently are. "The cesarean is the birth of the future" is a saying that is often quoted as having been stated by someone who is not currently present in the conversation. It is quoted by childbirth educators or by women themselves with a sense of surreality, a sense that this could happen and what would childbirth mean then? What would have happened to make this normal? That babies are more frequently born by cesarean is not something considered commonsensical at all.

Even if women do not contest the cesareans they are given, do not question their physicians, even if families demand cesareans for their daughters, and people are convinced that physicians give cesareans to their favored patients--in everyday conversation there is a sense of discomfort, of being trapped in processes that are much

larger than what any individual can control. There are generalized explanations in Mexican society that are leaned on when something is too large to explain, explanations that are thrown into the moment with a sigh and a shrug when the conversation is not going to resolve anything. The ones most often borrowed for explaining the cesarean are about corruption, about weak women, and maybe about changing times and the double-edged progress that comes from the north. They sound much like this, "Politicians, lawyers, priests, bankers, labor union leaders, taxi drivers and the police, they are all corrupt, it is logical to assume that doctors have to make a living as well." "In the past women used to be strong and moral leaders in their families. In these days, one has to make all kinds of concessions to making a living and working outside the home. Women just are not what they used to be. Not even in childbirth." "It is all these modern times, after all. People used to die in childbirth and there was nothing any of us could do. Now we have ways to save mothers and babies, but what has it done to us? What kind of price have we had to pay for this relationship to the goods and progress from the north?"

> United States has so much influence now. . . they do such and such and we just follow. Like the clothes, and the ads, and the television. We have this United States influence just kind of stuck with us and we have to live with it. Even things that we didn't used to do, like pre-cooked food, all this canned stuff, we have it all now. It isn't good for us either. We know, and all the doctors are aware, that all this diet stuff, light this, pre-cooked that, conserves and preservatives, cigarettes, chocolate and coca cola, all that stuff affects us. Of course what we eat affects us. I am talking especially about women in the reproductive time of their lives.
>
> Anita Contreras, Childbirth Educator, Centro Psico Profiláctico, north Mérida

The moment of "leaning" on these explanations, however, is a deeply ambivalent one. It is about conceding to powerful forces in creative ways to keep things going. The very people who throw the three generalized explanations into the end of a conversation about

cesareans are equally aware of other components in those explanations. For example: 1. Corruption is not simply an instrument of power itself, it is just as often a way to subvert power and distribute flows of money and information into channels for which it was not intended. 2. Mothers who re-imagine their relationship to pain and to home and to their children are everywhere creating new patterns of being mothers, the old patterns are simply too difficult to sustain. 3. If only the quest for progress and modernity would be tied to some other nation than the United States, a country which simultaneously has so much wealth and power and whose children shoot each other in primary schools.

Bio-power: Webs of "Productive" Subjugation

Maybe the question about the field of power relations exemplified in cosmopolitan medicine has to be read in another way. Maybe there are spaces in society in which personal non-resistance to cesareans can be read, not as silence in the face of common sense, but as a site for medical power to be coopted, interpreted and transformed into shapes of influence that can be used effectively in other arenas of life? This sounds more like Foucault's biopower, the way in which people participate through the micro-politics of everyday life within the webs of their own personal and social realms to create the conditions of their own subjugation. Foucault has been used in feminist writing to show how power is dispersed, as Bordo puts it, in a "non authoritarian, non-conspirational, and non-orchestrated" manner, located in everyday practices and yet still a part of an internalized disciplinary apparatus which "produces and normalizes bodies to serve prevailing relations of dominance and subjugation" (Bordo 1999:252). Power is not something anyone or any institution or governing body has, but is a dynamic network of

non-centralized forces. Power has to be looked at in the ways that it is useful, in the ways that it creates medical institutions, creates control over populations and bodies and urban space. In this way, people live out desires, identities and norms within a matrix of power which is part of the creation of a state (see Turner 1991).

This is important to an analysis of cesareans, because it is so much an arena in which the ability to control the rates has escaped the abilities of health policy to contain it, prevents physicians from escaping it, or the ability of individual women or their families to constrain it. During this research it became difficult to place either a consenting or resisting subject, partly because the taking on of agency and responsibility is something that few people wish to do. Cesareans, as mentioned above, are part of a tainted discourse. In personal narratives about cesarean it is easier to throw desire/agency away from the self, along with any suggestion of co-optation, complicity or consent. It is much easier to find narratives of blame, seeking out the others who could be held responsible. The women who chose to have a decisive voice in this arena, or better put who are willing to risk having a voice in this arena, were few and far between. For doctors, some of the same ambiguity existed as well. To say that one is manipulable by the women one attends is practically unthinkable, and stated as such by very few. To say that one's decisions to do cesareans are influenced by a willingness to do expensive and needless procedures is equally unthinkable, and not said even once in reference to a physician's own practice.

This silence could be interpreted as the production of docile, useful and productive and subjugated birthing bodies. But what does this mean for the people? Where do they position themselves? Medical anthropological work that uses bio-power as a way to

imagine power has to deal with ambiguity as to the micro-physics of power in praxis (Lock 1993a:140).

> But the body of Foucault's imagining is still, to a great extent, a body devoid of subjectivity and lacking the experience of power and powerlessness. What is missing is the existential, lived experience of the practical and practicing human subject. Foucault's negative notion of the body leaves us with a project that is essentially "self-defeating", in that it ignores the lived experience of the body-self. It is this dimension, the self-conscious, often-alienated individual and collective experiences of the body-self that critical interpretive medical anthropology returns to anthropology in the form of the "mindful body". It does so through the pressure exerted by its very subject matter: suffering bodies that refuse to be merely anaesthetized or metaphorized. In returning the missing, subjective body to the center of their inquiries, critical medical anthropologists invert the Foucauldian question to ask: "What kind of society does the body need, wish, and dream of?" (Lock and Scheper-Hughes 1996)

During one seminar at the Unidad de Ciencias Sociales on qualitative methods I asked if it was possible that Yucatecan women exercise no agency in birthing decisions, if Foucault's self-disciplined and docile bodies in the production of regimes of medicine was the way to understand power in medical encounters over birth. The professor, a Chilean, reminded me that in politics, Mexican women are passive, and probably passive in birthing decisions as well. I asked the Yucatecan women sitting around the table if they thought this described them adequately and the conversation turned, predictably, to the many examples in everyday Yucatecan life where women are active protagonists in family and public life. That evening Teresa, a fellow anthropologist, followed me to the parking lot with her own birth story to illustrate that she, like many other women she knows personally in Yucatán, do make their own choices. Central to her narrative was Teresa's relationship with her physician (a longstanding friend) and the way he asked her what kind of birth she wanted. She chose a vaginal birth, emphasizing that it was a difficult one, but she said he would have respected her decision regardless due to the terms of their

friendship. Would Teresa have told me this narrative if she had chosen a cesarean? Why was the key to her narrative the relationship with her physician and not the choice about mode of childbirth?

Silence can be found in un-expected places and needs to be read carefully. I thought I would find resistence in the voices of wealthy women, of resisting Maya women, or impoverished women. Women who would have a stake in the kind of birth they wanted in one sense or another. Abu-Lughod (1990) suggests that in order to find the structures of power, we need to read the resistance where it appears, and not look for it where it is not intended. To understand where resistances are, and the arenas of power that they are about, I had to look for the narratives in non-medical places.

Resistance itself has to be read inside out, in a way, resistance to being consumed by cultural explanations about the cesarean rather than struggling against the cesarean itself. This struggle within the relationships of what constitutes men and women, perfect babies and society is more important in the cesarean narratives than struggling against a medical system which is seen as embodying progress and modernity. It is not really useful for this question, as Good mentions below, to cast the medical system as solely the instrument of patriarchy and capitalist forces, even though it is most undeniably so.

> Medicine is not all war or exploitation, strident claims notwithstanding. It is also a conversation, a dance, a search for significance, the application of simple techniques that save lives and alleviate pain, and a complex technological imagination of immortality. It is a commodity desperately desired and fought for, perhaps even a "basic human right", even as it is a fundamental form of human relating. (Good 1994:60)

When the issues to be resisted are not about the shape of medicine, or the authority exerted in the medical encounter (themes which run through many birth narratives in

Europe and United States), where does ambiguity about cesarean abuse get expressed? How do discourses of privilege, sexuality, motherhood get encapsulated in these struggles?

In the following chapters I hope to show three of the many arenas in which women struggle to define the shape of their experience either in contrast to, or within, the social patterning of society which defines ideals of motherhood, bodies of mothers and babies, and struggles and negotiations over sexuality. This matters because it is about a social body, the body which ensures survival in times of rupture, crisis and pain. Urban life, hybrid cultures, learning to manage the social patterning of the landscape is not all about "fragilization" as Bertolloto refers to the disintegration of family units, the ruptures with traditional forms of authority, increasing troubles with intra-familial violence and child abuse - a popular way to write about the anomie of cities. He claims that the fragilization of social networks disturbs the transmission of information, values and adaptive modes which all play a key role in city health (Bertolloto 1997:4). I would argue that the narrative work encountered in cesarean narratives is about people's creative labor in struggling with the "fragilization" that Bertolloto names, creating bonds and connections, defining inclusions and exclusions in the social patterns of the city.

It is not important, in this case, to think about how people resist hegemonic medicine, or how they create the conditions of their subjugation in consuming medical resources and therefore shaping the medical apparatus that disciplines their bodies. Narrative is work, it is productive labor in the creation, reproduction and maintenance of social bodies.

CHAPTER THREE
MAKING MOTHERS

Writing outward from childbirth into the making of a mother requires a close look at both invisible but ever-present conventions, ideals and images which women confront and do so in a variety of ways. A deeply normative space in gendered power relations, it is sort of an imaginary place where women take on the various mantles of moral authority and keeper of well-being for their families. What that means, how it is taken on, and how much authority women can actually wield in this is the part that is inconstant, shifting and negotiated. "Birth is everywhere socially marked and shaped" (Jordan 1993:1)

This chapter addresses how women struggle with a normative space of motherhood which few actually fully embody, describes some of the shape of what they are contesting. How does a woman demonstrate her competence to take on this responsibility? Especially considering that being a mother is not only about having offspring, it is about reproducing society, about maintaining and ordering social bodies. This chapter focuses on two elements in the "making of a mother" that are represented particularly frequently through the frame of cesarean narratives: 1) womanhood and pain, and 2) the social body. This part runs particularly thick through the parts of the interview where women were simply asked to "tell me how it went with your cesarean."

These two themes are wrestled with in a narrative of birth, because they are signals of a woman's preparation to enter the world of motherhood. The first concerns her abilities

to demonstrate her strength and ability to suffer physical and emotional pain and still triumph. On the other hand, she must show that she has the social and economic support of her social body, the people who are committed to her and her future family. These two social goods develop in distinctive ways in different populations in the city of Mérida, but it is important to show how important they are in birth.

The interweaving of these two broad themes are important to hold side by side while reading the narratives of this chapter. Both of these themes, however, interweave under an sort of a reference point that there is a sort of set of social obligations implicit in the achievement of these social goods. A mother can be shown to have failed, and that happens daily. But she can also point to the failure of the responsibilities of society, community and family to her safety and well being, particularly in the moment of childbirth. The next part of this chapter deals with these two themes: pain and the social body, followed by a short section on social obligations.

Pain Templates for Cesarean Narratives

All of the women interviewed made a point of talking about how painful it is to recover from the cesarean. There was a lot of emphases on four moments of pain in the cesarean. 1) the *ráquia*[1], 2) during the operation, 3) *la levantada* (getting up after the cesarean), and the 4) pain of recovery. They described these four steps as counterposed to the way they may have suffered during vaginal birth. Maybe they did not suffer labor pains, and the terrible pain of expulsion which has taken on metaphorical power. . . but

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[1] A "ráquia" is the insertion of the epidural.

long needles inserted in the back during which one has to curl tight around the contractions which demand movement. Thirty seven percent of the women I interviewed insisted, in varying degrees, that they felt the pain of the incision, and the pulling of the baby from their body. All of them remarked on the "*levantada*," the first time they stood up after surgery which is a moment of terrible pain. Their bodies have been "split", the intestines laid aside, innards moved around, and the layers and layers of stitches used to put it back together. This creates layers and layers of suffering from which to recover. And everyone emphasized, in a variety of ways, the pain of recovery.

There were many differences in how women chose to respond to this pain. Some emphasize personal effort and stamina, for others it is important to show how much family was a support, but in all the interviews was present a discourse of pain. It is so pervasive that I began to understand this consistent narrative as a way that women signal that they have indeed passed through the pain of childbirth. They stand the idea that women who have cesareans are cowards and do not want to suffer the pain of childbirth on its head by saying that women who go through normal birth don't suffer very much, "just for a moment, and then they are right back to normal again." A cesarean, however, is a long-term pain.

Women appeared to return to this issue of pain, in one way or another, over and over again, assuring themselves and their listeners that they fulfilled their social obligations, at least, by suffering. The cesarean, in the popular image as birth without pain is strongly contested in the narratives. Pamela, quoted below, is concerned because she has learned that the cesarean is not simply "a cut in the abdomen" but an incision through many layers "the whole way to the uterus," and says that this means internal problems and possibilities

of "deep" infections, not just a surface incision. This pattern, with these four steps mentioned above, wove so consistently through the narratives I began to "feel" it as sort of a template. That I found it marked so clearly in a Pamela who had not yet given birth was also indicative. I met Pamela in a waiting room before interviewing her obstetrician. She invited me to her home to talk about her upcoming birth. She is one of two women I interviewed who had not yet given birth, and so their knowledge is what they have been given from relatives. I have marked the points in the "template" which correspond to the points given above.

> My mother tells me that it is a very long needle that they put in my back. Huay!, I'm not very afraid of injections, but this frightens me. (1) Then they tell me that you go numb below the waist, and my mother says that she did feel the incision because she was very "*alterada*" (nervous) during the birth, so the anesthesia didn't work for her. I am so afraid of feeling the incision. (2) Then she said that if I have a cesarean, I should lie very straight, not curled up, because when the incision closes, you are going to be in a curved posture. "Lay straight," she says, "it is going to hurt when you stand up, but once the incision is accustomed to being stretched it won't hurt anymore." (3) I'm not worried about the cesarean because of a scar in my stomach, but because being cut is something artificial and . . . like. . . no." *(later in the interview)* "You can't take care of your baby right away, because you are laying down, you can't take a bath, you can't give the baby this or that, you can't carry it. . . you can't change the diaper, so it is like it is days before you can even enjoy your own baby. (4)
>
> Pamela Pereyra, Fracc. del Parque, east Mérida

The cesarean protocols are templates in themselves; it is perhaps not a surprise that the stories of this experience carry the temporal imprint of the procedure. What is surprising is the degree to which they are repeated, appropriated and given meaning in a tale which strongly contests the idea that childbirth by cesarean is for physically weak women, women without courage. That the cesareans are perceived this way, a weak woman's way out, and will *"amolar"* (Yucatecan word for "ruined") her is a strong meta-narrative, and to struggle against it requires a lot of narrative work. Very few women

made an attempt to define the meta-narrative that they were contesting through their own stories, but two women did articulate this graphically. This first comment is from an anthropology colleague who works for a feminist organization in north Mérida, she defines the "old image" of childbirth, and how women became *muy mujer* (real woman) through childbirth.

> I have to tell you my image of childbirth. It is the idea I had, the idea I always had of motherhood, of birth and it was shared with all the young people of my time. I told you that I have a friend whose marriage failed because the first thing her husband said as a father when she had her baby by cesarean was, "Of all things, this is the worst, you can't even give birth." As if the fact she couldn't give birth meant that she wasn't a woman. It is a failure as a woman if you don't know how to give birth.
>
> This wasn't true in my case, having two cesareans in excellent conditions. The only problem I had was that I went into shock coming out the cesarean. My husband was more worried about the risk of the operation than he was worried that I would be devalued as a woman. None of that. But if we go back a bit, to the stories of my grandmothers. Each of my grandmothers had five healthy children with no complications and with midwives. They wouldn't talk about useful information like what to do about bleeding, about placentas, about how to get the phlegm from the babies. They just didn't talk about it, but they did want you to know that it is something entirely painful and difficult, but it is the experience that makes you strong *(muy mujer)* very much a woman. Those were the words of my grandmother, "You have to be very much a woman to give birth." You have to be very much a woman to bring children into the world. You have to be very much a woman, those were the words. A woman who cooks well, who attends her husband well, who takes good care of her children, and gives birth well, that is very woman. So, birth was something that exalts you, but something very painful.
>
> Elisa Vallegran Modena, Pensiones, northwest Mérida

In this second example, a midwife expresses what has gone wrong with a woman who has had a cesarean. She says a woman who has had a cesarean is a "disgrace" and couches it in terms of her inability to work hard enough, be strong enough to be a "real woman," her dependency on people to help her. I was so surprised afterwards to find out she was talking about herself.

If a woman has a normal birth, she can get up again without the help of anyone. To begin with, let's imagine that there is a lot of need for her to take care of her other children, or if she has a lot of obligations with her work, she can walk around without any problems. In contrast, a woman with a cesarean is a disgrace because you have to help her, she needs someone's help to stand up, to bathe, if she tries to do anything on her own, she feels it.

For a woman with a cesarean, she feels it when the climate is bad, the epidural gives her pains, she lays down, she is depressed. She is like a woman in menopause, her nerves are unbalanced, her blood pressure goes up and down. When she wants to pick something up, she feels a terrible sensation that not even I can explain to you. Those are the consequences of the cesarean, the reason they are never normal again. This is the truth."

Doña Consuelo, midwife with a cesarean herself. Col. Reyes, east Mérida

Building the Social Body

Crucial to the narrative structure is to show social relations, how each woman has social, economic and emotional resources in her social body. Childbirth is more than a physiological event, and negotiating the processes of folding and faulting of the social body seem to be more important in the cesarean narratives I heard than the need to protest a technological intervention, or the dominance of medical practices, or distress with the physician/patient encounter. "Where ever it takes place, no matter how "scientifically" conducted, birth is always a social relationship," says Pfeufer Kahn (1995:122), and it is at this level that women find it necessary to position themselves through talking about motherhood, about their families and friends, and pain and sexuality. These are the larger things at stake that appear to be shifting in the patterns of changing childbirth.

In Mexican society economic survival is a matter of creativity and extensive social networks. Even for the professional upper middle class, the demands of everyday expenses go beyond one and sometimes even two salaries. In a 1956 article, Wolf mentions the importance of negotiating both economic and political advantages in an

country where "in part due to the lack of capital in the Mexican economy as a whole," the "means of consolidating and obtaining power at the regional and national level . . . appears to be political" (Wolf 1956:1071). Wolf wrote that almost a half century ago, and the passing of time changes many things. But people who live in the Mexican economy over the decades since Wolf wrote have had no lack of opportunity to develop and use their expertise at negotiating "lack of capital" creatively. The earthquakes of inflation and economic plate tectonics makes the commonly used word "la crisis" keep forming and reforming new meanings and uses. Capital flows strongly through the upper stratospheres of Mexican society: the trick is to get it down where it can work in everyday life. One of my favorite parts of Wolf's analysis is to show that expertise at negotiating the "continuously changing friendships and alliances" which are constantly "forming and dissolving" is culturally patterned and learned (1956:1072). This means of juggling regional and national politics is just as important and deeply woven through the level of negotiating the relationships between family, neighbors and friends. Negotiating social bodies is a crucial part of making and maintaining a family situated in such a way to assure the survival of the next generation. Access to capital, to privilege, to political connections, to the right kinds of jobs are only possible through important social relationships that one creates and maintains around family. These relationships extend in many directions creating really interesting patterns in society. Lomnitz writes that while we can not ignore the profound vertical segmentation in Mexican society, one must also recognize that sociological analysis based on conventional assumptions about social class have run into so many difficulties precisely because there are such important groups and factions in which a class base is so absent (Lomnitz 1987:519). She shows how in Mexico City

political connections are horizontal through class, but also run vertically through the class structure through the webs of privilege and family. There is privilege negotiated in many other parts of society that carry just as much weight.

> Social reality is always more complicated than the models that social science is capable of formulating. In Mexico, economic class relations are affected by a structure of power that generates vertical hierarchies and by a structure of sociability that generates horizontal social networks. For each kind of relationship it is necessary to manage separate symbolic groups. All of this apparatus in its entirety constitutes Mexican culture. In this way, we can say that culture co-penetrates all of the social structures, is present in all transactions and gives form and content to all social relations. (Lomnitz 1987:550).

That this is important was demonstrated in one interview in which I was confused as to the process of labor that one interviewee was describing. She described being taken to the hospital and returned home because she was not yet "in labor" in spite of the fact that she had pains and she herself and her family were convinced the time was right. She described being taken to the hospital, once, twice, and a third time, each by different people. Her mother took her to the hospital. Her brother took her to the hospital. "Wait," I interrupt her in the interview, "when did you go the first time, what time was it?" I wanted a sequential narrative: one that began with contractions, and the repeated refusal of the hospital to admit her, ending up with the death of her child. That narrative was a narrative I was prepared to hear. She, in contrast, was telling me a narrative of "who?". Who were the players? Who were the people who participated in this process? She goes to the hospital (backed up by different family members) again and again, only to be turned away each time. Despite the mobilization of her social network and the many ways people all pitched in to help her, they, as a group, were unsuccessful, and the baby died. We were struggling over the shape of the narrative. I would understand an account of institutional

irresponsibility unfolding within a commonly understood time frame of one centimeter, one hour. She was telling me about the death of a child enfolded between the efforts of her entire social network. I was prepared to hear a death mapped within time and space. She wanted to tell me a death mapped by the confrontation of family and institution. My ears privileged malpractice as defined in wasted use of time. Her narrative privileged malpractice through the wasted use of family.

Another way this happened in the narratives was how women showed that their family insisted that the woman be attended in the best institution that they can afford. For a whole group of people, this is the IMSS. For others, this is a private clinic. Sometimes, however, the place of birth is less important than how a woman marks that there are relatives, work colleagues, friends who are obstetricians and will treat them with special consideration in public institutions. The family must show how they were vigilant, and insisted that the doctors showed first class attention to their daughter/daughter in law/ wife. Narrative strategy does not follow the "independence" and "self-help" frame which formed a great part of the women's health movement in the U.S. To do things alone, and without the help of anyone else is not a very great achievement. What is a great success is to share the experience with others and feel the support of those around you. The riches in the social body are measured in the people who are loyal, who are faithful, and who put a woman's well-being as a priority for them. That they care for her, accompany her, are very concrete demonstrations of social networks that are very important in an economy where economic survival requires the resources of many people.

The cesarean requires a greater output of supportive help, and fits into this pattern as well. One first time mother, director of one of the sections of the major newspaper in Yucatán put some of her ambiguity about this process like this:

> Another one of the advantages of a cesarean is that lots of people participate. Although sometimes I wonder if this is a disadvantage. Lots of people participate. Your mother, your grandmother, your mother-in-law, your little sister, your little brother, everyone who is family holds the baby. I think that the baby has a hard time figuring it all out, I think he hasn't figured out that I am mother, well. . . I suppose he knows I am his mother.
>
> Leticia Peraza de Montero, Jesús Carranza, north Central Mérida

Social Expectations

There is an implicit assumption underlying childbirth which provides a sort of normative frame, an ideal prototype which layers through society's many different social positions. It is a time of life when a woman can expect to be supported by kin, by friends, by community and by midwives, doctors, etc. It is a time when a woman should not have to be alone. This can be stretched in either direction. A woman who does give birth alone takes on something almost like a "super-mantle" of motherhood. A frequent element of midwife narratives is a story of giving birth alone. Through that experience, the community recognizes extra-ordinary ability and talent at birthing, and begins to call on her to attend other women. The other way it is stretched is that the "*Alli estuve solita*"/There I was all alone. It is a statement of great impoverishment and sadness.

This is in contrast to many U.S. and European stories of childbirth, when the mother asserts her mastery of the literature, and of community knowledge about birth in making the appropriate decisions, her screening of the physicians, and selecting care that is most in line with what "she wants" in childbirth. More-over, a birth story in Europe and U.S. is

likely to include a narrative of a struggle with medical personnel over procedures in which a woman either triumphs or experiences a "tragic" ending. Simply put, many birth stories are hero tales, in which the mother plays the primary part, and the narrative unfolds under her careful direction. Recent trends in U.S. birthing take carefully into account a woman's desires and comfort, either in the explosion of friendly birthing rooms, or through midwifery attended birth.

For many women, their side of these social expectations is to bear pain with fortitude, and bring forth a live baby. She can tell her child, for the rest of her life, that she suffered enormously in bringing him/her to life, and practically died. Since reciprocity is important, it takes a long time to work off that debt. Her family, especially her husband, mother and mother-in-law, and to lesser degrees other female kin and fathers should be interested, helpful and encouraging. These patterns are cast into even deeper relief when the birth is by cesarean. Has the woman borne her child with strength and fortitude, proving her abilities to take on the mantle of motherhood if she was under anesthesia and the baby was taken from her? The cesarean is, after all, major surgery which brings on much suffering in recovery. Does that count? As for the other side of these social obligations, has the shape of her social body mobilized and carried through their duty to see that her rights are protected, her safety assured, and her baby cared for until she can take up the responsibility herself? A cesarean requires the expenditure of enormous resources on the part of hospitals, and the attentive care of a whole cadre of medical professionals (physicians, nurses, anesthesiologists) and extra work for relatives and family during a difficult recovery period. Was the cesarean the ultimate expression of the obligation that society and family have to assure her safety, or was there a theft of

resources, and the woman's personal accomplishment of birth? Has the woman had to lean too heavily on her social body to recover and thereby violate some of the balance in these social expectations?

The other side of these social obligations is whether or not the social body has fulfilled their duty to care for her, protect a woman with safety and guarantee that her rights were protected. In some ways, she knits her social body through these stories, by making choices of how to tell the ways people fulfilled these obligations. Rosita lives in Garcia Gineres, a wealthy neighborhood in north central Mérida, but in a corner of the neighborhood that is very simple and almost impoverished. Rosita told me the narrative of her first cesarean, the hospital suddenly had too many women in Labor and Delivery and decided to discharge her with no warning. They put her in an ambulance, and sent her with her naked baby wrapped in a hospital gown. When she arrived home in this state, her mother-in-law was distraught. "She didn't know what to do. She ran out on the street, trying to find something to do about it." Her mother-in-law fulfilled the social obligations by wanting to, by expressing distress, by seeking answers she knew were not there. They were all powerless by larger structures beyond your control.

Mireye's husband had to learn to take on a voice of authority with medical structures through the death of their first son. The neighbor who introduced me to Mireye warned me that she was not fully aware of the blatant malpractice which was responsible for her first child's death after a cesarean, her family had decided to protect her from that information. So we have only her story, and it is a narrative of how her husband had to learn to defend his family's right to health care through the experience of failure. Mireye refers obliquely to the way she has been protected through the efforts of her family, by

telling me that her husband took the brunt of the suffering by dealing with the funeral arrangements and the hospital. Through this experience, he had to learn to take on the responsibility of the being the one in the family to demand good health care.

> Ever since what happened with the first child, he didn't want to (try for another normal childbirth). He has bad faith in doctors now. To this day, he can't swallow what happened. He just can't, he can't see them in good light anymore. And also, since what happened with my first son, he speaks now. In the Seguro, the truth is if you don't speak up, no one pays any attention to you. They throw you in the corner like an animal. You can see this yourself, we are not blind you know. We see them treat their relatives like kings. The way they treat their relatives is the way they should treat everyone else, after all, we pay for this care. No, they have their preferences with people, and that is why my husband just can't take it in. He can't, he just doesn't like them. Every since that time, anything that happens with his children, and ever since what happened to me, he says, "I am the authority here, I am the father of my children and I insist that you take care of them." That is the way you have to talk.
>
> Mireye Quiñones Alvaro, Melitón Salazar, south Mérida

In the following half of this chapter, I illustrate through a fuller treatment of three narratives some of the ways that women in different parts of Mérida society deal with the issues of how pain is negotiated in the cesarean and how social bodies are constructed. I hope to illustrate in this way some of the ways that women create their narratives about cesareans to confront the social terrains they must negotiate.

Three Ways to Tell a Cesarean

Narrative Turned Inside-out: Ada's story

But you can also fail miserably by "being there," as in Ada Isabel's narrative of her sister threatening to get a machete and give her a cesarean on the spot. Her narrative is filled with her sister's drunken resentment that this little, white, unmarried beautiful young woman in an impoverished, Maya-speaking family was aiming at a "painless" birth. Ana

is not in a position in this narrative to be able to label her social and economic resources in childbirth. But she works this creatively, sort of from the inside-out, telling the narrative instead of how the system failed her in spite of all her good intentions. . . The stories of harassment of doctors wove through her narrative as well, the statement that they would "put her in surgery where she would learn what pain was," and telling her that she would pay for her pleasure at conception by having "real pain" at her birth.

> All the six months that I was going for my check-ups, it was ugly. The doctors touch you so hard, they hurt you. Its natural, its all natural." (*Later in the interview. . .)* "When you are pregnant, the doctors say so many things to you. When they check and it hurts, they say, "and when you did it, it didn't hurt you? And they scold you, and they say, "when your baby is born, then you are really going to feel the good stuff." When they are doing their vaginal checks, it is hurting, and you tell your doctor (female) that it hurts, and she says, "Well, it should hurt, didn't you do it like this? Didn't it hurt when you did it? Well, just put up with it now so that you can become a *"chingona."* The THINGS they tell you. And you can't help think, the doctor is female, surely she has done the same things, but I bet nobody tells a doctor the kind of things they tell me.
>
> Ada Isabel Gallegos Guzmán, Melitón Salazar, south Mérida

Being beautiful, young, unmarried, she was trespassing seriously on the domains of "righteous" and "normative" motherhood and her narrative had to aimed resentfully at the entire structure to assert her claim to it. She had made the decision not to stay with the abusive young man who was the child's father, saying "for a little bit, I was sorry to think of the child without a father, but then I just got up and got on with things." She almost couldn't tell her narrative, her mother trying to intervene and tell her own, how this daughter of hers was born in a bedpan and she has called her *mierda* (shit) ever since. Ada determinedly kept talking, nursing her baby, demanding through her narrative that she had paid her dues, emphasizing her mother's blindness and epilepsy and dependence on her care and her income, much pain she stoically suffered during the pregnancy.

> Since I went really regularly to my check-ups, I asked my doctor why I hurt, why I have pain, and he said that it is normal to feel pain, everyone feels the same thing. So O.K., I say, that's fine, and I left. Later on, I still didn't feel well, since the beginning of my pregnancy my back hurt so much, so I just got used to pain. They told me to rest, but I never did. Who has time to lay around? *(later in interview)* "I'm not the kind of person that with a little pain just lies around, definitely pregnancy is a beautiful time, but you have to knowhow to manage it. Those women who have "Seguro" can lie around and sleep all day, but. . . (her mother breaks in to say drily that MOST women look for a *responsable* (responsible mans) with a job that has Seguro, and who can pay for things." If you want enough to eat, you have to do these things. I told her, "look daughter, look for someone responsible."

Her mother interjected at this point that the doctors really were not being fair. In her day, she had "eleven" children and made tortillas out of 30 kilos of *masa* (ground corn) every single day and "her" back never hurt. When Ada went into labor at 38 weeks, her family laughed at her impression that she was in pain, and since there was a big fight between her sister and her husband which resulted in the police taking away her brother-in-law, no one had time to take her to the hospital. Her sister suggested using their father's machete and giving her a cesarean right there. Her cousins arrived, saw what was happening, and took her to the hospital, where she was operated on immediately because it was a breech birth and she was already dilated. She mentions the pain of the epidural, she mentions not being anaesthetized properly, and then says the oft-quoted, "the only thing I wanted in the world was to see my child." She was "rudely instructed" to nurse her child with IV's and catheters still in her body, and when her child did not suck properly, they scolded her for having a "lazy baby." ("How," she asks me, "can a baby be lazy?") She was sent roughly to bath where she broke open three of her stitches, was told she could have nothing for pain because it would be addictive, and was scolded at every opportunity.

> Nobody come to help you, if they come, it is just to scold you, to tell you things. They don't help you change your clothes. If they come, they say, "oh, look at

how you have stained this here, now you ruined it." Oh, it bothered me so much, their scolding is so nasty. And you just have to take it all."

It is also important for her to point out that cesarean rates are rising, but it is not the fault of women who are cowards. She tells how her baby was in a breech position since the sixth month of pregnancy. She wondered, as she arrived at the already in labor if there was any chance they would just let her have her baby.

It is not about women being cowardly. The cesarean is very painful. I don't know what a normal birth is like because I did not feel it, but the cesarean is very painful. There are so many now because doctors will not risk your life. They won't risk your life even if you are crying and begging that you don't want a cesarean. They don't ask you what you want, they do what they have to do. In the old days, maybe they wouldn't have given me a cesarean when I begged them not to. I didn't want to have the cesarean, but it doesn't work that way. Later on I understood that it was better that he was saved, and that they didn't risk my life either.

She does not end her narrative in the hospital, but brings it back home, and to her mother who is sitting with us, under-mining her narrative at every opportunity. She tells in detail how there she was with an ailing mother and a new baby when her mother has epileptic attacks and she had to lift her off the floor and get help, leaving her baby in the hammock. She tore open her stitches and the following day the doctors had to put her back together with butterfly stitches.

From the moment I came home I was working so much here. I had a lot to do, taking care of my mother. She was here, what could I do? The people around here are such gossips, they just sit around criticizing people. I don't care what they say. But then I do think there are women like my niece, who has a cesarean who lays around and rests. "It is no big deal for you" I tell her, "where you gave birth, they help you stand up, they let you stay until you are better, not send you home the next day like me, and then they tell you to rest, but that is no excuse for "hanging" on people. It hurt me too, but oh well.

At the end of her account of the cesarean, she tells me that the experience is both *"barbara y bonita"* (barbaric and beautiful). Barbaric because it is intensely painful, and

beautiful because you "forget all the pain when you see your child." She repeats some standardized statements that you hear frequently about birth, quoted from a meta-narrative that everyone knows, carefully using it to frame her choice to become a single mother.

> Everyone has gone through this. If there are going to be single mothers without husbands, it is better to have them, than to abort them. There is a refrain that you will have them all your life, it isn't so much the pain of childbirth. Having them all our lives is going to be more painful than childbirth, or even more than a cesarean which is even more pain. What hurts the most is not childbirth, but that you must see this baby small, and when they are grown you will have to lay awake at night thinking about them.

At the end, when I ask her if she wishes to have another child, and how she would like to have the birth, she just says wistfully, "I would like someone to be there with me, so they can help me stand up, help me with my child. What I mean, is, I would just like to have someone, that's all."

The interview ended by the arrival of her brother-in-law asking for help in controlling her drunk sister who was raging, cursing and trying to hurt him for bringing her to her mother's house. The rain was heavy that day, he reminded us, and when he got home, she and her friends were drunk on a week-day afternoon, and his three children were locked out in the rain. Her mother told him to beat her, she deserved it. When he left to tend his wet children, it was an easy time for me to decide the interview was over. I left, driving through the rain and the dark of the evening. My 1982 Caribe drowned in the streets of water of south Mérida, and I sat in a little dark corner store, bought a soda, and listened to stories of troubled and tortured cars until mine dried out enough to get home. That night I dreamed of trying to get my family and my belongings out of a house that was flooding. Ada's narrative of her birth was struggling furiously to do just that. She had to fold the

narrative structure in on itself, and show everyone's failure to demonstrate her own strength.

Appropriation of the Narrative: Berta's story

Berta's narrative, on the other hand, tells her narrative from the inside out. Everything is perfect, not a hair out of place, all the i's dotted, and the t's crossed. She appropriates the need to weave a social body, the exigency to tell pain, but is also determined to write strength and self-sufficiency into her narrative as well. It is a formidable task, for a young woman working as an secretary, living in a simple, but neatly painted two bedroom house in Brisas (one of the modest middle class neighborhoods of east Mérida at the upper reaches of a sort of invisible border between "south" type neighborhoods and the "north"). I had trouble at first, finding her house. I had assumed it would be one of the larger ones on the street, I had been referred to her because she had taken Childbirth Education classes, something that generally more wealthy women can afford. Her house was the smallest, a one narrative house sandwiched between larger homes in a little dead end street. She told me her narrative in her air conditioned bedroom, with her young daughter sleeping on the bed between us. The maid was ironing clothes in the kitchen. In contrast to Ada who needs to cast her narrative against the idealized images, Berta wants to own the whole narrative, in all its parts, desperately.

She is also the only woman to use such strong statements about her will and choices in planning the cesarean. However, it is important NOT to portray yourself as a woman who actually chose her cesarean, so her statement is framed with a reference to the physician who did the ultrasound and how they kept "hoping" that the baby would turn.

> In every appointment the doctor who gave me the ultrasound would say, "Let's hope. . . let's see if she will turn" and she never did. So I chose the day, the hour, I programmed everything so it would all turn out right. I wanted her birthday to be near payday, and the sixteenth has bad memories for me, so I chose the fifteenth. Berta Rosado, Brisas, northeast Mérida

She also mentions her sister's decision for her second birth, explaining to me that if the first birth was a cesarean, the second would be the same.

> My sister is studying her doctorate in physical education, so she planned her birth to be able to pick up her classes again in 15 days. Imagine! It is one of the advantages of the cesarean that we can say, "On such and such day I am going to give birth, and I will recover in x amount of time, and so I can do this or that." With a normal birth you can't do something like that. . . the hour takes you, the day takes you. No, with a cesarean I can choose the hour and the day, it is perfect.

At another point in the interview, however, the narrative of her own will and choices in the planning the date of the birth is less clear, because it conflicts with another obligatory part of this narrative "for the good of the baby". The cesarean date of the fifteenth as her choice contradicts her own accounting of "waiting a few extra days," since her original due date was the twentieth or the twenty-first.

> My mother wasn't in Mérida, she had to go to Mexico City. My due date was the twentieth or twenty-first of August. Since the baby was breech since the seventh month, we gave the baby a few extra days to see if she would get into position, but no, she didn't. So, the doctor told me that getting to the ninth month, exactly, they would have to operate. I told my mother not to worry about it, I was fine with the help of the instructors, of the doctors and of God, that everything was going to be fine.

Her narrative begins by laying out the panorama of people who accompanied her, and her calm readiness for the event, even having the manicure and pedicure done. She not only has family members, but the childbirth instructor who is also the director of the childbirth education center is present from the beginning, and a teacher who came along. In the following portion take note of how the physician looks around the waiting room and

says cheerfully, "Nobody coming in?" enhancing the sense that this is a show. When her sister arrives in the room she refers to her as "costumed" rather than the medical word "gowned," and she is holding a camera in her hand.

> My cesarean was a marvelous experience. I got to my birth so tranquil. I gave birth on August fifteenth, they admitted me at 7:00 p.m. I was still having my manicure and pedicure, I was very calm. When I got to the hospital, my older sister was there who was also pregnant, her husband, my little sister who is 18 years old. Everyone was taking pictures. After we found the room, we take more pictures. Then there was a teacher who is very much a friend of mine who was also taking pictures. I changed my clothes, they shaved me, all of this they had explained in the course. They wrapped my legs, and my childbirth instructor was there from the moment that I arrived. Ana Alicia is such a incredible person. Then when they took me from my room, my sister waving good-bye. I was so so happy because I was so ready to have my daughter in my arms. My husband didn't want to be in the operation, but really, if he would have been there, it would have so nice for him, so he could see the birth of his daughter, but really I didn't need him for confidence, I brought confidence with me.
>
> When the doctor walked into the waiting room, he said, "Nobody is coming in?" And my sister said, "if you let me, I want to, really." When the doctor told me, "Your sister is coming in, I didn't believe him." I bent over so that they could put in my epidural, and when I got up, there was my sister, all in costume, covered up, holding the camera.

While in the above portion, she takes great care to name the positions of people in reference to her, she also points out in a sort of flippant manner that her husband's refusal to be in the operating room was his loss, she didn't need him. Simultaneously pulling people into the social body around her, she also is careful to point out that he plays a minor role. Berta is the same woman quoted in the last chapter as having a "few little arguments" with her husband during her pregnancy, because although the doctor said sex was O.K. through the seventh month, she decided for herself that the third month was the time to end sexual intimacy. "Imagine it" she says to me with familiar shake of head women often share when referring to men and their unruly desires. . . "of course it caused some problems." Berta herself is from Mexico City, having come with many other

Mexican families to Yucatán in search of a land that would never shake under their feet again. She married her husband (never given a name in our interview) who, she informs me, speaks Maya and comes from a Maya speaking family who were skeptical of her need for this cesarean.

> My mother-in-law did not think I should give birth at this clinic, because it cost $8,000 pesos. So we hardly ever talk about it. She wanted, she insisted that I walk a lot so that the baby would be born normally. "All my children were born normally, struggle for it, so your babies are born normally as well," she would tell me. "Well," I just told her, "It is a cesarean and there is nothing we can do about it. I am psychologically prepared for the pain if it is normal or if it is cesarean, whichever." Finally I just had to say, "You know what? It is a cesarean and I am happy about it." She was so affronted by that. So we really don't talk about it.
>
> *Later in the interview, she picks up the topic again.* "I tell you, my mother-in-law was determined that this baby be born normally. She had all her babies normally, and my husband was a breech birth himself. Just telling you that explains everything about her. *(I ask if she was attended by a midwife or a doctor)*. No, he was born with a doctor in the Clinica Mérida. Imagine what all they had to do to get him out, but she simply refused to let them operate, and said, "I don't care if it hurts, this is going to be a normal birth." All her babies were born normally. All her sisters-in-law as well.

Through out her narrative, another person plays a very significant role, her boss at the government agency where she works. He and his wife had a cesarean the year before, and his wife talked to Berta about her cesarean in glowing terms. Berta is convinced that the cesarean was positive and should be repeated. "You know, if I have another child, it will be cesarean as well, I am fascinated with the cesarean, it is really a super experience." When I asked her how she learned about childbirth, she mentions the childbirth education course, the magazine *Padres e Hijos*, (Parent's magazine), her mother, and her boss. At this point in her cesarean narrative, he appears as if he was present during the cesarean, she had me confused for a bit telling me this part.

> Then, because my boss had his baby a year ago, and he had gone in to see the birth, he was explaining everything to me, everything they do, because he saw it all. He said "they cut you like this, you can feel it, but it is not going to hurt you. They put your intestines to one side." All of this he had been telling me during my pregnancy. I am rather of a nervous sort, in spite of all the confidence I brought with me that everything was going to turn out O.K., I was afraid to feel that they were cutting me, even if it doesn't hurt me, so they started to clean my stomach, and I said to the doctor, "I can still feel" and really, I was never going to stop feeling, I just wasn't going to feel pain. Since the doctor saw that I was a little nervous that I would feel the cut, I faded. I think they gave me more anesthesia.

Except for the opening segment of her narrative above where she mentions in a phrase often repeated, "I was just so ready to have my baby in my arms," the baby up to this point has been fairly invisible. At this point, as the baby is born, she is drawn into the drama in rather formulaic terms.

> But I had told him that I wanted to be conscious when my daughter was born, and I wanted to see her. So I could feel myself going, my tongue fell asleep, I could hear everything that the doctors said, but I couldn't see anymore. What's more, I would answer them but in my inner being I couldn't talk. Then suddenly I heard the cry of my daughter which was absolutely divine. My tears ran down my face and I said, "Thank you God, thank you God for giving me the privilege of becoming a mother," and I said -- I remember saying this -- I said, "Thank you God, thank you Heavenly Father" They showed her to me and I turned and fell asleep. I didn't notice when they moved me. But first, I did see my daughter, they put her little foot here on my cheek, but I didn't feel when they put me in my room. When I opened my eyes, there was my husband beside me, thanking me because our daughter looks like him. There was my daughter, bathed, fixed up and everything, they brought her to me all perfect.

And the operation itself ends up on a perfect note. Later in the interview she mentions some of the cesarean scars she has seen on friends at work who were operated on in the IMSS. At the Seguro, she points out, all the incisions are done vertically and they have "horrible horrible cesareans, you can see the cut, and you can see the stitching on the sides of the incision. It's a horror, it is so ugly." In contrast, the end of the operation for her is perfect. In contrast to the majority of the women, quoted in the last chapter who

refer to the site of the operation as something physicians cared about much more than they did, Berta incorporates all the privilege of a horizontal, invisible scar right into the center of her narrative.

> Everything was perfect, my operation was a success. Of course, they gave me a horizontal cut, you can't see anything. Down low, almost in the pubic hair. And the incision, you can barely see the stitching, a little thread here or there. And when the doctor pulled them out. If I didn't know myself that I had been pregnant, I wouldn't have been able to tell myself. Everything was fine.

But it is not really safe to tell a cesarean narrative without pain. You must have pain and trouble as a new mother, or you will be subverting some of the "grand narrative" that you might need later, so right after this "perfect pronouncement, she goes right into the pain of it.

> But that is when the awful stuff happens, the pains. Because it really does hurt when the anesthesia fades. My room had air conditioning so I began to tremble. Without even wanting to, I trembled, even my mouth talked. My husband was sleeping on the couch, and I told him to get the doctor because I was trembling so much. So when the doctor came him, he said we should never have put on the air conditioning and that is why I was trembling. Then we slept the rest of the night. I chose to be operated on at night so that I would be able to rest, and in order to not talk, because that creates gases. The doctor put me on a bland diet for a week. So that I would not eat anything that would produce gas, because that DOES hurt, expelling gas is very painful and it makes it hard to sleep. I couldn't turn to either side because I felt like everything hurt. The next day they checked my incision, they couldn't move me, they left me there. I couldn't turn one way or that other.

But she does not stay in this painful space long. It is important to her to show how courage, and personal strength contribute to a successful and rapid recovery. This is the one point in the narrative where she speaks of how family helped her go counter to doctor's advice in order to recover first. Note, however, that it is not just any doctor's advice they choose to ignore, but the advice of an *eminencia* (eminence) who did not pay enough attention to her while he was doing his rounds. And note that the ever present

camera is recording this part of the narrative as well. The central actor, herself, at this point breaks down into needing help, she can't even dress the part of a beautiful mother, and needs help with the very basics of private hygiene: bathing and going to the restroom.

> This is terrible but the secret of this problem is the faster you get up and walk the faster you will get better. Even if it is the last thing you want to do. So my sister who now has her second baby told me to get up and walk, and I told her, "Its just that I can't, I feel like everything is going to drop out." Then my doctor came, Dr. Castillo, a very prestigious doctor, and I told him, "Dr., you know, I just can't get up." And he said in such a condescending way that made me feel really small, "Don't worry, when I come back tonight to check on you I will get you up." "No way," said my sister, "get up right now." So just the way I was, with all the burning and pain of my heart I got up like a little old grandmother, and did a few tiny steps. It was horrible, unfortunately none of the pictures that my sister took came out. I had my suitcase with my make-up, my hair spray and everything, so I could be a beautiful mother. But I just didn't have the spirit to fix myself up, not at all, not even to put on the gown that I took. The looser *(flojita)* you are, the sooner you will heal. One of my aunts bathed me because I couldn't even do that. I walked when ever I could. I would move a little here and there, because my sister kept saying, "If you want to feel good and not suffer, get up." So I got up, walked, and then got up and walked again. Even to go to the restroom I needed help. They move everything, your intestines, your insides and everything. Everything.

But this kind of immobility, inability to deal with the pain of the cesarean can not last long in this narrative. Within one day this brief engagement with pain is developing into strength and personal fortitude, and the scenery is again decorated with flowers and cameras and friends and family. She moves immediately from the last sentence above, to the successful ending.

> The next day I could go to the restroom myself. So then I started doing other things myself. That same Saturday night I started feeling very well, it was only one day since my operation. Saturday I felt really good, then Sunday in the morning they let me go. Sunday I got up by myself, I sat up and nursed my baby [of course I would give her *leche Materno* (breast milk)]. It didn't hurt me at all, they tell you it is going to hurt, but it didn't hurt me. Not at all. I bathed the baby myself, I combed myself, I put on make-up. I walked the whole way to the nursery and saw them put earrings in my daughter, I carried her and everything. There were lots of flowers, lots of photographs. I was so happy. The food was

> great, the attention was great, over there in Centro Médico Pensiones. I had a great time, they even brought me my television.

At this point, the narrative seems over. The cesarean is finished, she has successfully overcome pain, she is taking the route of nursing her own daughter, giving herself a "natural mother" kind of legitimacy, she is again able to make herself beautiful and to care for her own body. The flowers sent by loving friends and family and the photographs taken by the same people finish off the scene, enhanced by the incongruent image of a television moving with her as well. In the interview, however, while she moves forward into the homes of her sister and mother who care for her the next two weeks, she goes back into the experience of the cesarean a few times, making a few comments at the end, pointing back to various segments, as if to touch them up, apply a light paintbrush. One of those times was to emphasize the strength of her social body.

> They say that after birth you get postpartum depression. I think that is what happened to me on Saturday night because I didn't want to be alone. I was happy as a lark (*feliz de la vida*) because someone was with me, because the whole time there were lots of people around me. But then there came a moment that only my sister was there and she had to go, and I said, "please don't leave me alone" and she said, "you will only be alone for about an hour until our aunt gets here." And I said, "Please, please, don't leave me," because I knew if I was left alone I would cry. Thank God she didn't leave me. Other than that, no problems at all. None. Except for a few little arguments I've had with my husband since she was born. Then I do cry. But I look at my daughter, and she inspires feelings of love and tenderness in me, and I see that she is so innocent, none of this is her fault. No more depression, though.

Ada's narrative is about negotiating a system set against her. She is subject to insults, to being ignored by people who had the obligation to care for her. She then determinedly tells a narrative of personal achievement layered over the things that went wrong. Berta's narrative is also about personal achievement, a determined narrative of success. She has the intent, however, of telling how the system worked "for her," proving the measure of

her own social worth and fortitude. Little pieces of struggle insert themselves into her narrative, most especially the struggle with her husband and her mother-in-law who stand in the way of her dream birth and proving her social worth in an arena that they do not choose to understand. Both of the women claimed the pain and the strength to overcome it, and both carefully marked the successes and failures of their respective social bodies.

The Narrative So Made to Fit it Is Invisible: Andrea's story

Both Ada and Berta are struggling within class/ethnic positions and struggling to define themselves in relation to their access or distance from privilege. The need to demonstrate the qualities of strength through pain, and the social body fade as one lives more comfortably situated within privilege. One of women I interviewed in one of the elite neighborhoods of northern Mérida told me a rather brief narrative for her cesarean. Andrea was a very beautiful and elegant young woman hard to imagine as a mother. She seemed so incredibly young, even if she was twenty three years old. She has a college degree in design and worked part time in her husband's clothing factory, but now that they have their first child, she will dedicate all her time to the household. She is the last of five children in her own family, telling me that she is the *consentida* (pampered daughter) of her father who dotes on her. We sat in her elegant living room and were served cold orange juice by the maid. The nurse took care of the baby upstairs while we talked. I asked her if anyone in her household spoke Maya, and she said that she knew a little and could understand some words and phrases that she had learned from nannies who cared for her when she was young. Her mother-in-law, she said, speaks Maya because she was raised "with those people."

Her cesarean narrative was brief. While she and her husband disagree on how many children they want, and he didn't want her to have the cesarean, he is still very supportive. She experiences a great deal of support from her father, brothers, and her mother. Her mother-in-law is not even mentioned, and the only reason she mentioned her father and brothers was because I asked. The significant people in her cesarean narrative were her husband and her physician, and her mother. One of the main points of her narrative was the aesthetics of her body and the physical and emotional changes she had experienced. As in the other two narratives told here, I am not suggesting they are "typical" for their position in society, but there are patterns in the degree of engagement with the complexity of the social body mentioned, and the emphasis on suffering. Another woman in Andrea's position in society was well-read, well-informed as to all childbirth procedures and railed bitterly against the cesarean she was given.

Andrea begins her cesarean narrative with the reason for the cesarean, not at a temporal point as "when we arrived at the hospital." She situates the beginning of her narrative in the doctor's office, when he ordered an x-ray to see if the pelvic opening was large enough to allow the passage of the baby.

> Miguel and I were really happy until about 10 days before the birth when the doctor told me, "Look, I am going to have a *pelvimetria* (x-ray to check the size of the pelvis) done on you to see if you are "estrecha". They did the test, and it turned out that I was far too small for the head of the baby, and on top of that, the baby had a double circle of the cord around its neck. It was right there on the ultrasound.
>
> Andrea Carvajal de Montañez, Montealbán, north Mérida

So there are two reasons for a cesarean birth, but her husband does not agree. This comes up later in the interview as well, so I give both her comments here.

> Manuel was the only one who really didn't want a cesarean. He wanted a second opinion. He thought it was just the doctor, so they gave me the pelvimetria. Then he wanted me to go get a second opinion, because he said, "Of course the doctor is going to offer you a cesarean." The other doctor saw the same thing. So he was kind of in a bad humor about it being a cesarean. He was the only one, everyone else said it is the best for it to be born like this.
>
> Manuel told me, "all babies can come out, some come out breech birth." But, I told him, there is suffering, and you really shouldn't risk it. But Miguel, to this day, doesn't really accept this. He wanted to have lots of children, and since the cesarean limits you to only a maximum of four, more likely three, you can't really have a big family. He had such a wonderful time with his family that he wanted a lot of kids. Thank God, its not going to happen.

I repeated her last statement, "thank God it is not going to happen?" in a questioning voice, to encourage her to tell me more. She ignored this, unwilling to make more of an issue out of how many kids she wanted herself, and moved right into the next part of her narrative. In this sense, the cesarean for many women puts a welcome limit on how many children they actually want to have, and reduces the negotiations over number of children. Hilaria Maas Colli, an anthropologist at the Unidad de Ciencias Sociales is of the opinion that Mexican health planners are passive in the face of the rising cesarean rates in spite of the high costs because it helps them accomplish their demographic goals. She would go as far as to say that the high rates in Yucatecan village populations, of young adolescent girls with cesareans is over-looked because demographic controls are targeted especially at reducing the number of impoverished or indigenous people in Mexico.[2]

Andrea's narrative continues, saying "I wanted a natural birth, I don't know. . . to follow the way that nature has it. But oh well, we resigned ourselves to the cesarean even if we were frustrated by it," and tells how they programmed the cesarean for the thirty-

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[2] Hilaria Maas Colli. Comments following my research proposal presentation to the Unidad de Ciencias Sociales. October 1997.

ninth week of pregnancy. She says very little about the operation except that it went very well. I ask her who was present, and she says, "Everybody was there, there were lots of people," and mentions her mother with a camera to get a picture of the birth, her husband with a tape recorder for the first cry, and Ana Alicia, the Director of the childbirth Education center. Then she goes into a little more detail about how it felt to her.

> I didn't feel anything in the cesarean except for a little dizziness, and I felt like throwing up when they gave me the anesthesia. The operation went very well for me. I was awake the whole time until the baby was born and the anesthesiologist asked me if I would like to sleep while they stitched me up. And I said "yes" because I was a little nervous. Yes, I was nervous, my arms were trembling because they tie them down. They lay you down there, like being crucified. They tie you down in case there would be any reactions, as you are awake you know. That is when I felt dizzy. So they turned the bed a little bit, because I felt like I was drowning with my stomach, face up, I felt like I couldn't breathe laying like that. As soon as the baby was born, they brought him to me.

The pain after the cesarean is more prolonged for Andrea than it is for Berta and Ada, but it is still minimal in comparison with her friends, who need much longer to recover. But there is not the same anxiety of proving it as in Ada's account, that she must care for her mother and her baby, and in Berta's case, that she was competent to take care of the baby by herself.

> That first day, it was horrible, really horrible. I couldn't even move, but they made me get up, because they said it would be even worse if I didn't. So I started walking, and they told me I had to stand straight. I was like that for four or five days of a little pain, but I think it went pretty well for me. A week later I could go up and down the steps. Yes, the pain almost killed me, but I felt good, and I thought, well, it is your body. . . because I do have some friends, one of them didn't get up for a month. I was on my feet after five days. Another told me, "I couldn't get up for 15 days." All told, I think it went very well for me.

Andrea was in the hospital for two and half days, and then went home with "everybody", her mother and other family members who stayed with her the first night because the live-in nurse that she hired for the baby was not able to come until the

following day. While Andrea's cesarean narrative is brief, to the point and not very elaborated, she did talk more extensively than any other of the women I interviewed about the physical changes and emotional changes in pregnancy.

> I ate so much, everyone letting me eat anything I liked. And I was so susceptible to everything, I would read a novel and cry. I would see a movie and cry. I swelled up so much that they had to take me off salt. I had been very thin, very thin before. I'm better now, this is all just fat, but I had swollen up to a ridiculous degree. My own family didn't even recognize me. I got stretch marks all over my breasts, but not on my stomach. I got fatter. . . Since the fourth month I had been swollen up with just water, and then when the baby was born my body changed completely. The baby is two months old, and I feel like my ribs are wider, that my thorax has changed, yes my thorax. Maybe because the baby was up so high, and just wouldn't come down. My measurements just aren't the same up here. My waist more than anything. And I still have the stretch marks.
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> As for as emotional changes, when the baby was born I got so depressed. I was so sad. It had been a long time since I was so sad, but I knew it was just postpartum depression, It lasted me about a month. It was hard, because there I was, telling my husband I didn't like anything, and he had eternal patience. Since he has five sisters he is very patient with me, and understands me really well. He has never scolded me for crying, or for the physical changes. He says it is all normal and I shouldn't think about it, that it really isn't important.

I quoted Andrea in the last chapter where I mentioned how one of the factors that went into the decision for the cesarean came from her physician who was concerned that sexual performance could be compromised if he had to use forceps and episiotomies. Andrea made it clear she never heard anything like this from any of her family or friends, but her physician had mentioned it as something she should keep in mind.

All the women I interviewed who had gone to the childbirth education classes mentioned their "postpartum depression." One of them told me she only had it for three hours, and another told me about the "patches" that the doctor's recommend for depression. Luz Maria, mentioned above as from Monterrey knew the whole narrative of a "natural birth", saying she had wanted to see her placenta, wanted to feel labor pains,

wanted desperately to give birth naturally, but it did not work out in spite of all her efforts. She felt like something had gone wrong, insisting that she had an "adequate pelvis" and the baby should have been born normally. However, she was a minority voice, all her friends and families were in favor of the cesarean. She was wearing the patches for depression, saying that she was used to be a social being, going places and parties, and staying home alone all day with this new infant was driving her out of her mind. She was also so lonely, her mother had returned to Mexico City, and she really didn't have people to relate to in the elite neighborhood of "La Ceiba" (a wealthy community built around a golf course eight kilometers north of Mérida). In her narrative, she resists the need to tell a narrative of pain, saying that the old ideas of *valentia mexicana* (Mexican courage) were not part of her desire for a natural birth. She herself, she told me, had lots of other ways to prove herself in modern times. She simply wanted to know what it felt like, was ready to ask for anesthesia immediately if she changed her mind, not like the young women who come out of surgery sobbing and apologizing to their husbands.

Conclusion

In this chapter, I show how women from three different parts of Mérida, the south, the middle and the north, representing varying degrees of privilege, create their narratives of cesareans in different relationships to an imagined ideal of good motherhood: a mother with a wide social circle of friendships and resources, and a woman capable of gaining moral authority through her ability to conquer pain. While Ada had to tell the narrative "inside out", showing all the breakdowns in the system in order to tell her own personal narrative of success, Berta's narrative claims the "ideal" prototype and determinedly

shapes the narrative to make it true for her own life. Andrea, on the other hand, really didn't have to engage with the master narrative, no one is going to contest her right to motherhood or her position in society. Her narrative is effortlessly simple, really not that developed. It has nothing to resist or claim.

The next chapter will address another aspect of being a mother in a social body. What is the relationship between the mother and the child within? How is this mother-baby body imagined in popular and medical terms, and how have the meanings of that relationship shifted over time and with the philosophical and practical changes in medicine? How do these shifts in the way these two bodies are imagined influence the way physicians, women and their families in different parts of Mérida approach childbirth?

CHAPTER FOUR
MOTHER-BABY BODY

At the core of the social body talked about in childbirth is a mothered body, a body which releases a child into a social space defined as family and contested as such. In this chapter, I wish to examine how images of this already social body of mother and child in one unit has experienced shifts and is defined in different ways. The mothered body during pregnancy is already "reaping" the benefits and paying the costs for both bodies, both in terms of physical demands and social responsibilities.

The primary focus of this chapter is to show how the image of a mother-baby body which works hard together through labor to become strong persons on their own is slowly giving way to an image of an adverse relationship in which the mother is a container that must be opened, and the baby a still being which needs to be removed. In the first way of imagining the two bodies in childbirth, the baby "helps" by moving, struggling, participating in birth. The mother can not be expected to birth on her own; the very nature of childbirth is a collaborative effort between two beings. In medical language, this mother-baby social being is referred to as a "*binómio*" and treated as two patients in a not necessarily harmonious relationship.

This shift in how the social body of mother-baby is imagined is laid over two other images of process and change that draw from two "distant" points that converge on the present moment of hospital births and cesareans. One of the distant points is geographic

and cultural, and the other is temporal. As mentioned in the section about the city of Mérida, the view from the city, from the resource rich hospitals and the apex of technology and education out towards the hinterlands of villages and indigenous Mexico, is interpreted and told in much the same way as a look to the past. Throughout this research there were references to the *en los pueblos* (in the towns), the rural places of Yucatán out on the imagined peripheries of "indigenous," "local" and "popular", where midwives and the women they attend live in poverty and suffer traumatic births in contrast to the "center" of civilization, the city with its orientation towards the technological and wealthy north. There, in the urban center, the new, the safe and the modern enters childbirth: anesthesia remakes the landscapes of pain, sterile surroundings replace the dirt and chaos of village life, and safety and security enters the moment of childbirth. Midwives are considered important and necessary to deal with the women too poor or too distant to come to hospitals and clinics. Midwives are also admired from a safe distance, along with the altars of *janal pixán*[1], the *jarana* dancing, the *vacquerias*: cultural symbols of rural Yucatán. These references overlapped in ambiguous ways with the *antes cuando* (times past) when women and babies suffered and died from obstructed labors, hemorrhages and from unsterile conditions. This past full of suffering is erased from the present by imagining a future where no mother or baby dies. Non-death is expanded into an image of generous well-being in which neither the body of the baby, or of the mother (in that order), are marked by the traumas and pains of childbirth. In both cases, however, it appears that

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[1] *Janal Pixán* literally translates as "spirit food", the name of All Saint's Day in Yucatán. In other parts of Mexico this time of the year is known as *Todos Santos*, a day when families remember those who have died with alters, flowers and prayers.

women were made of stronger stuff than they are now in the "present", in the "city", where women are weak and eat *comida chatarra* (junk food), drink coca cola, live stressful lives and lose a sense of what true mothering is all about. Babies are born safer through cesareans now, but women are seen as weaker and become slightly suspect mothers for bearing the consequences of modernity.

Images from the Cultural and Geographically Distant in the Center of the Cesarean

One of the philosophical differences between midwife-attended birth and medical knowledge is the understanding of the mother's body and the baby's body and the interaction between the two. The word *binómio* (the medical word used for the mother/fetus body: one body, yet two) as used by obstetricians separates both bodies, making the good of either one independent of the good for the other, and admits the possibility of conflicts which must be resolved through medical intervention. Rothman pointed out in 1982 that the mother/fetus are seen in the medical model as a conflicting dyad rather than as an integral unit (1982:48). Martin describes U.S. obstetrics, "Medical imagery juxtaposes two pictures: the uterus as a machine that produces the baby and the woman as laborer who produces the baby. Perhaps at times the two come together in a consistent form as the woman-laborer whose uterus-machine produces the baby" (Martin, page 63). The baby as an active participant, a collaborator, a being who the mother can count on to assist in reproduction has disappeared from these descriptions of childbirth.

In Yucatec midwifery, the *sobadas* (pre-natal massage) before childbirth and the *amarrada* (binding) post birth are both to help the mother's body adjust to the movement of the baby. Doña Delia pointed out that in the same way that men need sobadas to re-

align their bodies after hard work in the milpas, a mother's body needs re-alignment after the hard work of childbirth. The mother's body is imagined to open up in terms of veins and bones, and internal organs can be displaced through the physical demands of childbirth. Through the monthly pre-natal sobadas, a midwife also re-aligns internal organs and moves the baby into more comfortable positions for the mother. A sobada is a temporary measure to provide comfort to the mother, because it is understood that a baby will probably resume the positions it prefers within a few days. The image of a new baby, bending, struggling, pushing its way out into the world is not the medical image of the baby as needing to be removed from its container.

This image of a cooperating mother-baby unit can probably best be illustrated by the narrative of an interview in 1993 where I was taken to see a midwife in a village a few miles from Mérida's northwestern periphery by two SSA nurses. The nurses had been observing my study of midwifery in the center of the city and determined that I interview a midwife who was "real" to a deeper degree than the midwives they thought I could possibly find in Mérida. The circumstances of the interview disturbed me. First of all, the midwife was asked to come to the home of the health promoter and set before me for the interview. Secondly, the nurses and the health promoter, wanting to be helpful to my research, created the sidelines and made occasional contributions to the conversation to demonstrate their knowledge of "traditional" practices and their support for midwifery. Last, I could barely understand the midwife myself. Her language was difficult for me to follow. I was just beginning to feel/decipher the vocabulary, rhythm, pattern and flow of Yucatec Maya Spanish and probably sounded rather incomprehensible to her myself with my particular constellation of Bolivian, U.S. and central Mexico accents. The surface

interaction was a supportive, collegial atmosphere. The underlying tensions in the room were the known but not spoken issues of midwife's loss of clientele, her age, and her apparent incoherence. I realized later, struggling for hours over the transcriptions, that some of the incoherence of her narratives was that they were defensive - an explanation of a series of tragedies that were directed at the nurses with me. I did not know those stories, but all of the others present did. Her stories were not answers to my questions.

One of the narratives she told encapsulates the concepts of strength and pain and how to think about the moving, active baby during birth. A young woman in the community was married to an older man, and had been attended by Doña Rosa in a series of births that ended tragically. Doña Rosa roundly blamed the father for continuing to try for children, saying that he was obviously too old to produce healthy offspring and should stop risking the life of his young wife in the effort. The narrative I remember the most clearly was about the last birth, where the woman struggled valiantly to birth her child who died during labor. Doña Rosa told me (the nurses with me) that once the baby died, nothing they did could help the young woman because the baby was no longer collaborating to be born. She told the young woman she had to go to the hospital and have the baby cut out. There was no way to avoid the surgery because the baby was dead and the mother was already exhausted with the effort to do the work for both of them.

Doña Delia, a midwife in southern Mérida, has told me on numerous occasions that in addition to a skilled and kind midwife, there are two crucial elements for a successful birth. A courageous woman in labor must work hard with her contractions. Doña Delia puts this in her oft-repeated advice to women, *"Haz de tu parte, mamacita"* ("Do your part, little mother"), and a baby who must do their part in enhancing the strength and pains

of the contractions by moving vigorously through the birth canal. *"El dolor, cuando comience, es que el nené está trabajando."* ("The pain, when it starts, means that the baby is working"). These characteristics are integral to a safe and successful childbirth, and when absent are an explanation as to why a normal childbirth failed and a cesarean was necessary.

What is of course interesting to me, is to find this image from the "cultural hinterlands", where the nurses of SSA thought I could find the appropriate amount of distance, deeply embedded in stories of cesareans in the city of Mérida. The baby who fails the task of contributing to the strength and pain of childbirth in the struggle to be born is an important part of physician's and nurse's explanations to mothers as to why a cesarean was necessary.

Three Examples

In the following section, three women's narratives of what went wrong in childbirth hinges on the failure of the child to produce pains/strength for birth. One of the women I interviewed had an experience much like Doña Rosa described, only she was in the Clinica Esperanza, an evangelical private clinic in the center of Mérida. I didn't realize her first child was stillborn until she mentioned it in an entirely flat tone, wrapping the narrative in medicalized, de-personalized language and referring to the baby in the medical jargon of "product." Flora lives with her extended family in the center of the city. Her husband is a bus driver, her brother owns a small store, and the family takes turns attending it. Flora studied a commercial career in accounting, but now dedicates all her time to the raising of her sons, particularly caring for the one who has hearing problems.

Before asking her to tell me about her cesarean, I asked if she had any other surgeries in her life, and she mentions a D&C, and tells a simple, stark, short narrative where the baby, dead, can not give her enough strength to be born. She got there, "very slowly" on her own.

> Before I had a cesarean, I had a normal birth. The product died because it was wrapped up in the umbilical cord, but it was still born normally. They had to help me with forceps because it was now a lost product. So I did get to my nine of dilation but very slowly. The baby didn't have any strength or anything. So, I did manage to get its head out, then the doctors had to take out the product and then they gave me a D&C.[2]
>
> Flora Kumul, Inhalambrica, Central Mérida

There are two inter-connected elements in this way of imaging the mother-baby body. First of all is the image of the active baby, mentioned above, who contributes to a successful birth, and the second is how this activity on the part of the baby contributes to the force of the contractions. Both of these elements are present in the narrative shared with me by Delia[3] Cruz Yerves, a 19 year old young woman who came from Coatzacoalcos, Veracruz four years ago with her parents and finished secondary school in Mérida. The father of her child is a young man who works as a janitor. I met Delia in the O'Horán and interviewed her a few weeks later in her simple cement block home in the vary far south of the city.

> After this the doctor went to check me and he said that I needed two centimeters more so that I could have my baby. He said that I was getting along well and that I would have my baby normally. I think it was only about 10 minutes later, maybe 15, it is hard to know how much, I was there with my pains and the people came. They told me they were going to give me a cesarean, and that was

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[2] Dilatation and cutterage. A surgical procedure to remove whatever had remained in the uterus after the stillbirth.

> when they put me in the surgery and they did my cesarean. They told me it was because the little girl didn't help me. I mean that she wasn't pushing. She wasn't strong enough to help. My pains were all in my hips, there where I was opening, but I didn't feel her movement, I couldn't feel that she was helping birth her. She was very calm. The doctor said to me that she. . . that when he would check my dilation she would go back up in. She did not want to come down, and well. . . they had to do a cesarean on me. I was doing fine and such little time was left and I had advanced so far, and I wanted to endure to the end. But I think that they saw that the girl wasn't helping me, and they decided to do me my cesarean.
>
> Delia Cruz Yerves, Paseos de Itzincab, south Mérida

While this narrative shows how the failure of the baby to help in the birth resulted in a cesarean, the second part of her explanation which is significant is the part about the pains of birth. "My pains were all in my hips, there where I was opening, but I didn't feel her movement, I couldn't feel that she was helping birth her ."

This is the side of pain that Doña Delia refers to when she says that in the hospital they do not know how to help a woman give birth, all they know how to do is take her strength away. In Maya one of the words for pain is "*ki'inan*," a continual, intense, and pulsing pain. Ki'inan, however, also means "strength, vigor, fortitude, a robust and strong cause." A elderly male midwife in the village of Tzucacab says that the pain of childbirth is *Ki'inan u paala'lobo'*, the strength/pain of the baby (Güémez Pineda 2000). The double meaning of the word "ki'inan" simultaneously refers to pain and strength. When midwives in Mérida say they "help" women, they are often referring to the oxytocin shots they can give which increase a woman's strength by increasing the force of her contractions (Good Maust 1995:92). By increasing the intensity of the contractions, the degree of force available to a laboring woman is enhanced. Pain is a woman's strength, it is the contribution of the baby she is birthing. Two things can take this strength away according to Doña Delia, the shame you can feel in the hospital, and the anesthesia they

give you. Both of these actions are negative, being un-helpful, not contributing to a successful outcome.

While Doña Delia focuses on the hospital's lack of helping a woman develop her pains, Luz describes her experience at the hospital in favorable terms because she was given injections to speed up her pains. Luz is a young woman from south Mérida, who has gone to trade school for both tailoring and sewing, and worked as a promoter in a local supermarket. She lives in a village-style home with a stone wall around the front, and is surrounded by little furniture and lots of human activity. Her two year old daughter was dressed in a lacy little dress, freshly bathed and powdered when I showed up for my interview. Luz really enjoyed telling me her narrative complete to the last gory details about vomiting. Her parents are from Mérida, and her grandparents from a village and she said that none of them could speak Maya. She began her narrative telling me about a large pain she felt a few days prior to birth, going back and forth to the hospital with a sequence of family members to check and see if she was in labor. The third time she went, the hospital staff admitted her, not because she was in labor, but because they said they didn't want to be blamed in the future for not attending her when she insisted. They began giving her injections, which Luz refers to as a "help" in that it increased her contractions, but it wasn't enough because she did not dilate. She understands the doctor's explanation that the baby did not change position as her baby's lack of cooperation in birth. Failure to be assisted, helped out and encouraged was not the fault of the hospital, but rather of her unborn child. The hospital had done what they could, but since her baby did not cooperate, they had to give her a cesarean.

> They had given me already two injections. Two injections they had given me and I had some pains, but I just didn't dilate. So just before they put me into surgery they tell me that they are going to operate because the baby refused to turn, it doesn't turn. It is on one side, it was on this side and it didn't turn. She just didn't move. So when I had that pain two days earlier it was when she turned. Because of that she didn't turn, she wouldn't pivot. She didn't want to move. I had pains, because of the injections they gave me but she wouldn't turn. Just before the operation the doctor checked me again, and no. . . she didn't turn. He told me he had to operate because the time was passing and I had a fever.
>
> Luz del Carmen Solíz, Melitón Salazar, south Mérida

In the three examples above, the young women interpreted their cesareans as being necessary because the baby did not contribute strength and pain to the birth. Also in both cases, they felt like hospital personnel had done all they could be giving them injections which are also seen as giving strength by the increasing of pains. In the narratives above, it is important to point out that the explanations for the failure of the baby to act were told to the young mothers by medical personnel in the hospital. In the narrative below, the mother is told that the baby is not strong enough to make it through birth because of a weak heart. She is convinced this means that he is unable to help in the birth, but she has a strong sense that something went wrong, she does not entirely believe the explanations she was given. When I was taken to her home for the interview, her neighbor asked me not to press about the reasons for the baby's death. Her family and neighbors had hidden from her the extent of the malpractice that resulted in the death of her baby from her, because they were afraid she would not be able to handle it.

> When I was pregnant with my first son, everything was fine with the midwife where I was going. I also went to the Seguro. But the nine months ran out, twenty extra days passed and nothing happened. After the twenty days, I started feeling bad, I began to feel bad so I went to the midwife, but she didn't want to attend me because I had a fever. I had a lot of fever, and she said she would not be responsible for me, it would be better to go to the doctor. So they took me there, and they couldn't get the fever down either. I really had bad luck. I really had very bad treatment because it was Sunday and there are no doctors. The one

who took care of me, I never actually saw her. I didn't even see her face, I only heard her voice, it was very curt. She was the last one to come.

The doctors came by and they were checking me. The baby was going to be born normal, that is what the midwife told me. Then they put that little thing, like a radio you know, where you hear the heartbeat of the baby. Then they told me that the baby was coming with a bad heart. I was in so much pain, and in comes this doctor, I think she was the doctor on call. All she said was, "Take her to surgery and just operate on her right now." That is how she said it, just like that "Get her into surgery."

I didn't want them to operate, and my husband didn't want that either, so I went out. I went out to cry because I didn't want this. I wanted my baby to be born well because he was coming fine. Then I met another woman in the room who said to me, "Don't risk something happening to your baby. You don't know what might happen." She talked to me and convinced me so I went and signed. I signed the permission for them to operate. In the end, it was all for nothing. My baby died anyway. The doctors had told me that when you push, the baby needs to work too, and since he had a bad heart he wouldn't be able to do that. They would have to take him out with forceps. So that is what they did to me. It was very hard.

I got such bad care, why pretend and tell you otherwise? I got very bad care. The doctor who was on call was a despot in the way she treated me. She would come, and grab you as if you were an animal. She doesn't even notice if it hurts you or not, she is treating you like an animal, "Just put her in surgery right now and get it over with," she said it just like that. And they put me in surgery.

Mireye Quiñones Alvaro, Melitón Salazar, south Mérida

In all four of these narratives, it appears that women are told by hospital personnel that their babies have not contributed to the successful outcome of the birth. It is also possible that statements such as "your baby has a bad heart and can not survive the stress of birth" can be interpreted by the mother as "your baby has a bad heart and will not be able to help in the birth." We find this reasoning at the endpoint in women's narratives of why their babies did not help them enough to give birth normally.

From the Images of the "Antes Cuando:"

The second form of distancing that is present in the cesarean is the narratives of the "*antes cuando*" and how cesareans are the answer to birth traumas. The deep past is

written through a window of memories of the near past, with forceps, damaged babies and damaged mothers haunting the older generation of doctors who struggled to find alternatives to death through the cesarean, and their protegees who then improved on the old cesareans with their terrifying memories as well. In this part of the chapter, I first show how these images of damage frame the current efforts to erase the effects of traumatic births on the lives of children. A stress free birth where a baby is lifted out of the womb so as to have no damages to their future intellectual abilities. Secondly, I show how these images translate into a search for aesthetically beautiful babies.

Dr. Fernando Gásque López has written extensively, along with Dr. Carlos Urzaiz Jimenez, on the history of the cesarean in Yucatán. In their writing, they write a sort of history of kinship and evolution of a medical body of physicians through the changes in obstetrics during last century (Urzaiz 1980, Gasque 1999). The first cesarean was done 1897, when both the mother and child died shortly after the birth. The first cesarean is referred to as a tragedy, called a "bloody act," and no one dared attempt another for 10 more years. In 1907 the second attempt is referred to as "mutilating." The mother survived and the baby died during the surgery. Ten years again passed until another cesarean was attempted, this time in 1917. The word "mutilating" remained to describe the operation, even if both mother and child survived (Gasque 1999). The cesarean was a big change over what was past, but the memories of all the difficulties they had in those days are a vivid part of the present.

> We used to have to face the problem of infections, and there were no antibiotics. We had to face the problem of hemorrhages and there were no blood transfusions. We had to face the problem of Rh, and we didn't know what was going on. We had to face the problem of dystocia due to different abnormal presentations, or for cephalo-pelvic disproportion. What did the women do?

> They couldn't give birth. All these cases we now can resolve with a cesarean. There is a saying that we have. "Birth should be easy. Easy by natural paths, or easy with a cesarean."
>
> Dr. Hugo Tamayo, corporate private care

These memories of the terrible births in the "old times" underlies much of the deep appreciation for the ease of cesareans in the present. In this first case, I quote a very old, recently retired obstetrician who is referred to with deep respect as one of the only remaining *parteros*[4] by the childbirth educators. He has a long memory of the difficulties of attending birth in his own "before", having lived much of the twentieth century through his own experience and through the experiences of the physicians who trained him. This period was one of a great deal of experimentation and learning how to attend birth in hospitals, much in how Wertz and Wertz (1977) demonstrate how and when this shift taking place in the United States. The problems with forceps deliveries are etched on his memories, repairs and long-term suffering for the mother, and disabilities that children then had to live with.

> You have to understand that many of the births in the old days were maneuvers with forceps. These were extractions that produced a certain rate of morbidity in women and children. In the past, you would walk down the streets and just see children with problems like twisted arms. Women suffered so much in those times. We had to do so many vaginal repairs: problems with the bladder, problems with the uterus, with prolapses. . . We don't have to do that kind of surgery anymore. Some of those repairs were also due to the fact that babies used to be born at home, which for all practical purposes is a thing of the past now. The traumas and the tears, we just don't see them anymore. This is a benefit for the doctors, for the mothers and for the babies.
>
> Dr. Jaime Abram Estrada, corporate private care

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[4] *"Partero"* means "male midwife," and is one of the terms that Dr. Carlos Urzaiz refers to as a term of disrespect that obstetricians left behind when they took on *ginecobstetra* (Ob-gyn) and *médico cirujano* (surgeon). It is used today by childbirth educators to refer to the few doctors who know the art of attending birth rather than the art of surgery.

Dr. Tamayo, quoted above in how obstetrics has changed from the time that there were so many death, also spoke about the pressures to produce perfection in all facets of childbirth. While Dr. Abram emphasizes the morbidity for mothers, Dr. Tamayo talks about a shift in this orientation, from caring for the mother, to having to care for both. He prefaced the quote below reminding me that a physician now attends a binómio, the two bodies in one, and the obstetrician is equally responsible to both. Both fetal distress and maternal exhaustion have to be weighed in the balance, but his words belie the emphasis on the baby.

> First of all, we were content if the mother was alive. Then we began to think that not only the mother, but her baby must live as well. Then we had to make sure that the mother come out of childbirth in magnificent conditions, and that the baby be alive, and more than anything else that there be no cerebral damage. This has made us work harder to assure that childbirth doesn't last as long. A prolonged birth with impaired oxygen to the brain in the uterus during childbirth can cause cerebral paralysis. Then you also have what we call "minimal cerebral damage." This is represented by intangibles such as dyslexia and other small abnormalities of a central nervous type: such as irritability, less than adequate learning abilities, and many other things that show that the child is not functioning to their full capacity. This is the motive, I would say, behind the number of cesareans today.
>
> Dr. Hugo Tamayo Menéndez, corporate private care

With these images vivid on the mind, the use of forceps is shrouded by concern. The use of forceps fades to the background as they are supplanted by cesareans considered much safer. Ironically, however, obvious in the words of Dr. Tamayo above, the image of the cesarean becomes (rather than an alternative to the brain damage that can be done by forceps) a more generalized alternative to brain damage itself. The first doctor I interviewed (Dr. Cardenas Lara from the Clinica Mérida, who also asked not to have his words taped) blamed the current paranoia about forceps and vaginal birth on all the research done by psychologists on birth traumas and the way popular magazines

sensationalize these reports. Unfortunately, he told me, women read more now, but they stick to the distortions to these reports written up like novels in popular magazines like Cosmopolitan and Vanidades, rather than the original research reports. The feeling he gets from his patients is that there is a general and widespread fear that a baby will be brain damaged in the birth process. If a little boy doesn't play soccer perfectly, ride bike early, or read in kindergarten, it is the fault of the obstetrician for leaving him too long in the birth canal. If the parents themselves do not mention this, the neurologist or the pediatrician will do it for them, telling them that many of these problems originate in childbirth. As past president of the College of Obstetricians and Gynecologists of Yucatán, one of his responsibilities was reviewing all the lawsuits brought against the members.

> Add to the widespread fear of brain damage, the culture of lawsuits that comes from your country, and a doctor's life is simply hell now. Even if you are blameless as a physician, anything you say will be twisted and held against you. You must suffer in silence and take on a submissive attitude if you want to keep your practice. . . Prudence, on the other hand, is not an admirable trait in a physician anymore, only aggressive medicine. I will never be sorry for doing an unnecessary cesarean, but I can be very sorry for not doing one at the right time.
>
> Dr. Cardenas Lara, corporate private care

One woman, who works in labor and delivery, told me about the birth of her grandchild which she saw born by forceps. She told me that the doctor used forceps so silently and with such expertise that her daughter never knew that they had been applied. Due to her loyalty to the physician, and her respect for him as one of the last great parteros of Mérida, she has never mentioned it to her daughter. Her desire to keep this information even from her own daughter shows how deeply embedded the fear of forceps has gone.

For the current generation of doctors, the cesarean has become more than an alternative to forceps, or an alternative to death and morbidity. The cesarean begins to be imagined as an alternative to brain damage itself. The baby lifted from the womb with no struggle is a baby who is healthy, happy and beautiful. The fear of brain damage if the baby is inside the mother's body too long then becomes linked to an impression that the passage of the baby through the birth canal is the cause of morbidity in both mothers and children. At this point, I focus on how language about cesarean causes is geared primarily towards the possible negative impact on the baby of being "forced" through the vaginal canal, a very different image than that of a baby pushing, bending, and contributing to strength. The impression about the negative impact for the baby on going through the birth canal are portrayed both in aesthetic terms and in terms of too much stress and potential life-threatening disorders. The director of the childbirth education center said that pediatrician complaints about babies which need active massage and stimulation have gone up since cesareans have become such a common way of birth[5].

Fear of Brain Damage

Increasingly, the well-being of a new baby is measured in terms of its potential for future intellectual and physical accomplishments. It is not enough to simply "have all the parts" intact, but that the birth process not impair brain function in any way. These concerns have led to a change in obstetrical practices, where both the use of forceps and a

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5 Personal communication, Ana Alicia Cervera.

prolonged birth which impedes oxygen flow to the baby's brain are seen as harmful and to be avoided at all costs.

> We have to think about perinatal results, how these babies are coming out. Before, it was all the same, everyone was born with childbirth, but how many children had problems - cerebral paralysis, convulsions. . . how do I tell you this, it is not just a matter of managing it so that a woman has a natural birth, but there is a child all damaged, or somewhat damaged. Sometimes the problems are bad enough to result in troubles in school. That is what the psychologists of today say. Psychologists are the ones that know about this.
>
> Dra. Jacquelín Echanove Dávila, Ob-Gyn, private practice in the north

This worry has led to a shortening of the time that a "normal labor" is supposed to take. Both institutional concerns over efficiency and time management mesh perfectly with the increased concern among families about long births and the ill effects on brain development. In childbirth education classes, women are taught to expect to dilate "one centimeter per hour" even though what they actually encounter in a private clinic is that a normal birth is not expected to take more than four to six hours before going to surgery (Director, Childbirth Education Center). In public hospitals, the *partograma*[6] is strictly followed, with the same "one centimeter per hour" expected (Carillo 1999). Midwives frequently mention these changing images of time as one of the most pervasive "ills" that lead to more cesareans. They are used to seeing births take anywhere from a few hours to a few days.

Another aspect that exacerbates this issue is that many births in the private hospitals are induced - with obstetricans and mothers not willing to wait after the fortieth week of gestation.

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[6] The partograma is form of hospital record-keeping in which a time line of the progress of labor is kept. It is a graph of the time line that birth is supposed to take. Progress in centimeters dilated is charted along with the minutes and hours of birth.

> And you know. . . sometimes God's hour has not yet come, and they do the cesarean. When I went to the Centro Materno, I saw this. What I saw was that the time hasn't come, and they say, "Operation!" And it hasn't begun to open up little by little yet. Every few minutes they are going to check. Until dilation is like this (shows me with her hand) the baby can come out. They don't wait for the right hour, and that is why they do a cesarean. Doctors just want it, "Fast!"
>
> Doña Socorro Utz Chi, Midwife, Pancho Villa, outer eastern periphery of Mérida.

The length of time spent in the vaginal canal is not only dangerous to the child because of the deprivation of oxygen and the resulting damage to the brain, but also damage to the head because of hitting against the bony pelvis. Dra. Gonzalez, a renowned obstetrician in a prestigious private hospital, talked very briefly about the birth of her son 25 years ago. She tells me, hitting one fist repeatedly against the flat palm of her other hand, that she had to have a cesarean after 15 hours of labor, and her son's face showed the effects. "He suffered so much," she told me, "His face was all smashed up like he had been in a boxing match."

Dra. Erlinda Alcocer Menéndez, Director of Obstetrics and Gynecology at the O'Horán hospital expresses this view of the vaginal canal as a "pelvis which is a bone", a bony passage dangerous for babies. She is caught in a real dilemma. As director of public hospital with a high rate of cesareans, partly because they are referred problems from the whole peninsula, she is under a great deal of national and international pressure to reduce the expense created by high rates of cesareans[7].

> I was talking with a psychiatrist, and we were talking about the causes of the alterations that a child can experience: such as slow learning, epilepsia, dyslexia and others. He mentioned that in 90% of the cases, they think that it is probably

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[7] I was told rather bitterly, by the physician-statistician who keeps the records and quite politely prevented me from getting official information (from him) on the current rates at the O'Horán, that this same pressure is not experienced by the private hospitals which have much higher rates.

caused by obstetrics. Of course this is going to make me think. Here I am putting a patient through labor for what we would consider a reasonable length of time, but the whole time this little head is hitting against a pelvis which is a bone for 12 to 18 hours. There has to be some kind of damage, imagine an adult putting their head in a tube and banging, banging. . . something has to happen. So this you have think about this as well. . .

As a woman, I am particularly concerned about the welfare of that baby who is in there banging its head for six hours. As a physician, should I let it go on more time knowing that there could be more problems later? That influences me a lot. There really is no method or technology that absolutely lets me know if the baby is O. K. Then I would be able to say with confidence, "Go ahead, everything is fine, continue." If I knew, I would just hold back, but how? There are no sophisticated methods. . . there are monitors, but they just tell me what is happening with the heart, but how is the baby? What kind of changes are going on while I am waiting for labor, what can tell me? We just don't have the equipment that could tell us what is going on here. These babies that come in at 41 weeks, or 42 weeks, how am I to say that everything is fine. . . "put her into labor, no problem." I just can't do that.

I think that being on the front line . . . or in front of a patient, watching it take such a long time and all that . . . I think that this of planning at your desk is really easy, yes? That is the way they plan wars. I don't think it is the right way to plan to reduce cesarean levels if I don't carefully examine what the consequences will be, not? O.K. Let's reduce cesareans. O.K. But am I going to bring more disabled children into the world, more children with neurological problems, more mental retardation, more epilepsy? That is what reducing my cesarean rates is going to be about. These are health issues as well. Right now I reduce my rates, but these children will be damaged for life. This is an expense in special schools, specialized treatments, more money that parents have to spend, the creation of special centers for children with dyslexia and mental retardation. I think it is better to make sure babies don't have problems than to reduce my rate of cesareans. That is my way of thinking.

Dra. Erlinda Alcocer Menéndez, SS, Public hospital

This concern about length of labor and the repercussions on the mental abilities of children born in prolonged labors is exacerbated in Yucatán by the additional concern that a Maya heritage means both that Yucatecan women have small pelvises (commonly referred to in medical jargon which has become popularized as *estrechez* (narrow pelvis/tightness) due to their very small stature, and that their children have a wide head

circumference: two of the ways that Maya people are perceived as different from other Mexican indigenous groups.

> I also think it is important to repeat that the anthropological factor is very important. For example, here the Maya woman, for example is characteristically short, overweight. Yes. This influences the kind of hips, or the kind of pelvis that she has. Here it is very common, for example, that we have a patient with a fetus of 2.7 - 2.8 kilos, and we had to operate because of cephalo-pelvic disproportion. In other hospitals, they could say to us that is impossible, such a small fetus. But our patient is 1.3, 1.4 meters high, short. With hips that are totally narrow. So, I think that the anthropomorphic factors are very important. At least here, in our southeastern region, our Mayas - basically the population that we attend in this hospital. Dr. Armando Manrique, O'Horán, public hospital

When I interviewed Dr. Carlos Urzaiz Jimenez mentioned above in reference to the work on the history of cesarean, he referred me to a study published comparing women's height, and the baby birth weight. The study showed, he said, that in northern Mexico, the women are taller, and have smaller babies than the women in Yucatán who are shorter and have babies with a higher birth weight. While many of the physicians told me that this is one of the reasons for the high rates of cesarean in the peninsula, when I invited four of them to a conference panel to present different aspects of high cesareans in the peninsula and asked them to elaborate afterwards on the common perception that Maya women were too small to give birth, they all, together, laughed it off as utter nonsense.[8]

In the same way that many Yucatecan women can never compete in beauty contexts (excluded by their small stature) neither do they often meet the "riskfree" conditions for birth which indicate that a height of 1.5 meters is the minimum normal height. A nurse who has worked in the O'Horán for over fifteen years was one of the many people who

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[8] Part of the "La Cesárea en Yucatán: Aspectos Médicos y Socio-culturales." I Simpósio Regional de Salud Reproductiva: "Más Allá de la Reproducción." C.I.R. Unidad Biomédica. Universidad Autónoma de Yucatán. Mérida, Yucatán. May 1999.

explained this to me. She said that since the O'Horán is a hospital where many of the Maya of the peninsula are referred, there is the problem of the small pelvises which contribute to the high cesarean rates. I asked her how she had her own babies, and she said that since she was such a small woman, hers were born cesarean. Curious, I asked her about her mother, her sisters and her aunts. Were they taller than she is? "No," she said thoughtfully, she was actually the tallest of them all, and yet all of their her cousins, brothers and sisters had been born at home in Valladolid. I asked her why this was so, and she simply sat there quietly, looking at me for a long silent moment and then said, "I don't know."

A fellow anthropologist from CINVESTAD, a research center in Mérida, Betty Faust, said that one of the local healers she works with explains that cephalopelvic disproportion is due to the large quantities of pre-natal vitamins that women are given in the clinics. Taking the vitamins causes their babies to grow beyond the size at which they would normally be born. Another explanation was given by Doña Consuelo, a midwife in east Mérida.

> In the old days there were more midwives than doctors, and there were midwives who knew how to fix the times that a baby was lying crosswise, or sitting, so we had no problems. Many women actually even knew how to attend themselves. But, what has happened now? Besides the fact that all people eat these days is pure fertilizers, women are less courageous, less strong, and medical science hasn't been able to add any knowledge to this situation. The baby is lying cross-ways? ¡No! Do a cesarean! Breech baby? No! Do a cesarean. Even if they are perfectly aware that there are people around who know how to fix this. Oh no! Don't go to midwives for massages, because they are going to kill your baby.
>
> Doña Consuelo Ramirez Cutz, midwife, Colonia Reyes, east Mérida

Midwives complain that there is a great deal of medical negligence that happens in this area. The narrative that follows about saving a woman from a cesarean[9] was again told by Doña Consuelo. I replicate this narrative in its entirety, because the whole narrative represents a challenge to the medical system for leaping to conclusions about the narrow pelvis with no proof. And she points out so carefully at the end that the bones must have their time to widen. Instead of seeing the vaginal canal as an impossible cement ring, she talks about the slow opening of the bones that comes with the hours of birth. The first part of this narrative is how this young couple came to Mérida to give birth in the O'Horán. The woman's first birth had been by cesarean in the town of Oxkutzcab, due to this same problem, referred to as the afore-mentioned narrow pelvis. The couple decided that if she had to have another cesarean, they would come to Mérida before the baby was born and have it born in the O'Horán to assure themselves of good care. A neighbor on the same rental property heard they were going for the cesarean and laughed, telling them to go find Doña Consuelo. Doña Consuelo picks up the narrative there.

> Well, they didn't think about it one more minute, they came right away to me and they began to explain it to me. "I'm 'estrecha'," she told me.
>
> "Well, who told you that?," I said.
>
> "Well, the doctors," she replied.
>
> "O.K., do you know something?" I tell her, "it isn't because I am against science, because I am a part of it, but the truth is you also have to understand something else. The last word is God's, He is the creator of everything. He decides everything. If you have confidence in what I say, you are going to have to let me check you, and then I will tell you if you can or can not (give birth). (*in an aside to me,* "If I see that a person is really 'estrecha', I'm not going to risk her life, because I would be risking both her life and that of her child. But if I see

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[9] Important to note that while she tells this narrative, she also qualifies it afterwards by saying, "you have to know where to step and where not to. Unless two or three years have passed, I tell the couple that they have to pay for their irresponsibility and just take the cesarean. The womb has not healed well enough to risk it."

that the person is not 'estrecha', then I believe that it is important to save her (*from the cesarean)* that is good to do, not?")

So I checked this little woman, and I saw that she was not tight. I told her, "Look, what happens is that sometimes there is medical negligence, please pardon me for saying so, but it is the truth."

"Is that so?" she says, "Would you be willing to try to help me?"

"If you have confidence in me, sure," I told her, "but if you would rather, I can give you a paper that will get you into the Centro Medico where it will be cheaper for you."

"You know something, I don't think so," is what her husband said. They thought about it and decided. "Whatever it costs me, even if it is expensive like $2,000 pesos" he says to me, "do it, whatever you need, do it. I really prefer that they don't give a cesarean to my wife, especially for the sake of my other child," he says, "On the first one they gave her a cesarean, and that is why we had to come here this time."

"So" I said to him, "Look, you know something? I don't want you to think that it is for lots of money that I am going to do what I am going to do. I charge a fair price for my work, just what is fair, and then it is over with." That is what I told him. "Yes."

"Don't worry," he says to me, "she is just going to stay here."

"In that case," I say, "I do need a few tests done." I took her to the Centro Materno, I took her with Dr. Echeverría and they told her the very same thing, (*that she would need a cesarean*). She still had a month left, or three weeks.

"Right now I tell you" the doctor said to her, "tomorrow or day after tomorrow they will give you a cesarean."

"It is going to be a cesarean?" I laughed and I told him, "You know what doctor? This woman here is going to have a baby normally. Her baby is going to be born normally. She is not 'estrecha'."

He just sat there looking at me. "Don't risk yourself" he told her. "You are going to risk your own life, and that of your baby."

She didn't even answer him. "O.K., doctor" she said, and got up. She didn't say "yes" to him and she didn't say "no." They gave her the order to deposit blood and she never did it, and when the hour of her pain came, they brought her to me.

"You have to have patience," I told her, "let me tell you why. Because to receive a birth like this, it is going to be your first one. Why is this your first birth? I will explain this to you. Let's see if you understand me," I said, "It is your first birth because the first one was a cesarean, so the bones never got to open up. It will take its time, thanks be to God," I tell them.

In reality they did have confidence in me, because they waited for the moment that I was telling them about, and the baby was born. It was a boy and the husband was so happy. Last week they stopped by, and they told me that another one has been born. She had that one normal as well, right there in her village.

Doña Consuelo Ramirez Cutz, midwife, Colonia Reyes, east Mérida

Aesthetic Concerns

In addition to the idea that forceps or a traumatic birth can cause damage to a child is the aesthetic aspect mentioned above that a baby born in a stress free cesarean is born beautiful, with no wrinkles, no bruises, and they look a month old on the day of their birth. Marina, a historian who grew up in a village east of Mérida, said that her father was not interested in seeing a newborn, because they are always so ugly, but her own children were born so beautiful because they did not have to suffer the trauma of the birth.

> I can remember when my father. . . when my baby was born he didn't want (to see) her. He said, "All babies are ugly when they are born, Marina, they are wrinkled and all." My mother encouraged him, saying "Come on, come see her, she is beautiful." When my father went to see her he said, "How is it possible that a baby be born like this?" I have to tell you I don't know. The way my children were born is normal for me. What I mean is that my babies were not born with the wrinkles and grease and stuff. I don't know, but I would think that it is because they are simply lifted up, they don't have to suffer, so they are born as if they had a month, or month and a half. My father was entranced.
>
> Marina Fleites, Jardines de Pensiones, west Mérida

This perception is then taken the following step, from appreciation of the aesthetics of a baby born through cesarean, to a perception that stress is bad for the baby and the cesarean is designed to protect the baby from over-work. This is the case of Ada, introduced to me by one of my son's friend's mothers. Ada is a young mother with three children who runs a dance studio and has worked as a receptionist for an obstetrician. She lives in the western reaches of the city, the burgeoning middle class neighborhoods where many people from central Mexico settle. She herself came from Tabasco fourteen years ago, and married a Yucatecan man from Mérida.

> My first pregnancy six years ago was rather complicated. I was in absolute bed rest for seven months . My son was premature. I went into labor and the doctor told me that to prevent fatigue on the part of the baby it was better to do a cesarean, then there would be less fetal suffering. Those were the words of the

> doctor who gave me the cesarean. The baby was born, and he spent 8-10 days in the incubator. I had dilated just a little, but the fear was that the baby would weaken too much. So the doctor said, "You know? It is just better to do a cesarean."
>
> Ada Patricia Marrufo, Pensiones, west Mérida

Luz María is a young woman from Mexico City who had come to Mérida after living for awhile in Monterrey, Mexico's technology capital. She came with her husband to work with the Fiesta Americana, one of Mérida's most elite hotel/convention center/luxury shopping areas. They live north of Mérida in a gated community by a golf course known for the beautiful colonial homes. She conscientiously took the childbirth education classes from the Centro Psico Profiláctico in north Mérida and was convinced she would be able to give birth vaginally because she is "tall with an ample pelvis." She was so disappointed when all but one of her entire group of cohorts in her classes gave birth by cesarean, and was so disappointed to have a cesarean herself. Luz María said she just wanted to know "what it felt like" to give birth vaginally, even though she made a point of saying she had no need to suffer to prove her social and moral worth as in the "old times". None of her cousins or friends had given birth vaginally. She wanted this in spite of the fact her family and friends told her that cesareans were better for both her and the baby.

> But so many people around me said, "(just have a) cesarean," for one reason or another. My father one time said that now it is very normal to program your cesarean. Many of my friends did this. One of my friends is in Monterrey, another one is in Veracruz. They have babies, they both had cesareans and they are happy, they tell me it is better to be cesarean. You plan it, they say, you don't suffer, nothing happens to you. Your baby doesn't even suffer, and it is born beautiful, much cleaner. In a way it is true, because they really do come out beautiful, no swelling, not purple, none of that, not? They said it is better to program (your cesarean), the cesarean is better now.
>
> Luz Maria de la Loria Gallindo, La Ceiba. north of Mérida

In this way, the stretch from the stretching, moving, bending baby who contributes to the successful outcome of a birth is brought around to the image of a baby who is lifted from the womb without suffering is the most beautiful and the most intelligent.

In this chapter, I have shown a shift in the way that mother-baby bodies are imagined in childbirth, which has shifted from images of active participation of both members to the idea that the journey of birth through a mother's body becomes a hazardous process which can compromise the beauty and intelligence of the child. The way that the baby's help during childbirth is essential to a good outcome is being superceded by a narrative in which the mother herself is a hazard to good outcomes. The labor of both bodies is suspect.

This narratives that make up this chapter are primarily about the baby's experience in the mothered body. As shown above, there are also many concerns about the suffering and trauma of childbirth on the mother's body as well. In this next chapter, we look at how childbirth and cesareans are counter-posed in images of sexuality and motherhood.

CHAPTER FIVE
THE MAKING AND UN-MAKING OF SEXUALITY IN CESAREANS

Under-lying my thesis questions is a curiosity about how gender relations are portrayed, acted out, represented, and lived through the telescope of medicine and childbirth. The previous chapters have addressed these issues through what it means to be a mother in a social body, and what it means to be a mother-baby unit. In this chapter, I examine how the cesarean becomes a part of images and negotiations over sexuality.

Just as a person might study gendered relations through the rich imagery of Yucatecan poetry as in the oft-quoted, *Las mujeres que se pintan* (Women who wear make-up) done practically weekly on the central plaza for tourists and Sunday-outing Yucatecans; or in the paintings of women by the famous Yucatecan artist Castro Pacheco; or in the passions, costumes and parties of the exclusively female "Carnaval Feminil" in northern Mérida: cesareans are a moment, a spot in time to catch refracted views of gender and sexuality.

It would be a mistake to read this chapter as a way of setting out arenas of sexuality that women "find" and "fit" in cesareans, or to imagine the cesarean as a means by which certain women take on identities comfortable to them. The very event of a cesarean, the possibility of giving birth through the abdomen creates a whirlpool of discourses about motherhood, virginity, ethnicity and pain. Michie and Cahn (1996) show that the cesarean activates all kinds of ambivalence about "normative gender ideals" and "natural sexuality." Women, in their narratives about cesareans, felt the need to address some of

these spaces either by asserting their rights to "normativity" or by taking the opportunity to explain how rupture with those ideas was necessary.

Michie and Cahn, analyzing the activism of the natural childbirth movement write:

> by asserting a "nature" to which women giving birth must conform, advocates of natural childbirth run the risk of activating a series of deeply problematic ties between women and nature that are, themselves, ironically implicated in what feminists might otherwise recognize as specifically cultural norms of femininity and heterosexuality. (Michie and Cahn 1996:55).

In Mexico these "deeply problematic ties between women and nature" also take place within an enduring exclusion of the category rural and/or indigenous from what is cosmopolitan, urban and privileged. People think of midwives are always rural and indigenous, that indigenous women have more ability to deal with pain, more stoic approaches to life, and less interest in issues pertaining to their sexuality. This perception of indigenous being more like "nature," the opposite of a cosmopolitan urban person is so deeply embedded in people's thinking that they strongly circumscribe the type of care that women receive.

The stories and statements that follow are rarely comments that people make about themselves. The cesarean seems to be the epitome of creating discourses about "others." It causes discomfort that is difficult to own and appropriate. None of the women interviewed claimed that they had sought out and demanded a cesarean, although images of other women who manipulate their doctors into giving them cesareans were part of every single interview's discursive frame. The responsibility for cesareans is always placed at "other's" feet: greedy or hurried doctors; cowardly women; demanding and fearful families; young and pampered rich girls; working women with no time to become real mothers; indigenous or impoverished women who don't go to pre-natal care;

midwives who "manipulate" women; and doctors in village clinics who contaminate women before sending them on. In much the same way, implications for sexuality in the cesareans are often about others as well.

Sexuality is knit deeply into the moment of childbirth. Bodies are given social meaning in relationship to others. The birth of a first child is also the birth of a mother and a father (contested, of course, in various ways), who have been and are sexual beings, but find the shapes and meanings of that sexuality modified with the pregnancy and birth of a new person. To be woman in Mexico is still so framed within the context of motherhood[1] and all the possible meanings that can be negotiated through that lens, that an examination of the ways that motherhood/sexuality are struggled with at the moment of childbirth is important. This chapter addresses four aspects of sex and sexuality that emerged in the interviews. 1) How the cesarean can be desired as a place for de-sexualizing the experience of childbirth. 2) How women and their physicians compare the issues of aesthetics and sexual function after vaginal and cesarean birth. 3) The ways in which women can use their experiences of the cesarean to negotiate the terms of returning to sexual intimacy. 4) How issues of sexuality and ethnicity weave together in the actual techniques of the cesareans.

Cesareans: A De-sexualized Birth

In a cesarean operation, a woman is saved in some ways from the degree of genital exposure and the lithotomy position in the hospital which are so easily confused with

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[1] this is not to ignore the struggles to redefine arenas for changing this, but to remind us of the hegemonic nature of motherhood as defining the very being of a woman.

sexual dominance and control. In public hospitals in Mérida, women do a great deal of the pushing for birth in the main room with other birthing mothers. While curtains could be pulled around the beds, they most often are not. Women are instructed to lie flat on their backs, with a pillow under their heads, holding their legs apart by gripping their own knees as wide apart and as high as possible and to stay in that position pushing as long as necessary. Different residents come by to check dilation and progress, supervising doctors wander around supervising, social workers stop by different beds for women who already given birth, to give lectures on lactation and birth control, nurses stop by to adjust bedpans, check the pitocin drip, etc. There is the normal flow of people around the labor and delivery room, and four and eight women in the same room at the same time, depending on the hospital. One obstetrician, now working high in the IMSS administrative offices in Mexico City, described his memories of working in Labor and Delivery as working in hell: women pushing babies out all around, too much work, too many patients, no time, and so much suffering and pain.

That women are subject to demeaning procedures that embarrass them during childbirth is nothing new, part of young girl's training to go to obstetricians and gynecologists is to teach her that this is not about sex, that this is neutral territory, that all these things happening to her publically are asexual. Gladys talked to me a bit about her first pre-natal exam, which embarrassed her terribly.

> Oh, how embarrassing it is when it is the first time. I remember when I got there, they said, "Take off your panties." ¡Huay!, I didn't want to, and I told her so. I didn't want him to see it, so the girl says to me, "Don't you worry, he sees you like, like he is not going to look at you that way *(morbosamente)*, don't worry." Yes, that's true, I say to myself, he is used to seeing these things I say to myself. They made me get up there, I don't know what all she was doing, she was saying

> that I shouldn't be embarrassed, that it is all normal, that I should be calm and I don't know what all else she said. Then that boy checked me and that was it.
> Gladys Figueroa Flores, Meliton Salazar, south Mérida

Using the word "boy" to refer to the physician who checked her emphasized how inappropriate it felt to her. But the sexuality of giving birth, from the beginning of the medical encounter, is played down, made medical, made sterile.

The childbirth education center in north Mérida sponsors a visit to one of the local private clinics for their clients about one month before giving birth in order to de-mystify the locale and help women understand the process of birth in the hospital. Once in the delivery room, Isolda, a little younger than the rest of the women on the visit, cautiously reached out her hand toward the metal frames of the stirrups on the delivery table, then she hastily put it back in her pockets, remembering that this was a sterile field. The only question she asked in the room was, "Where will I put my underwear?" to which she received no answer. On the way home in the car she announced that her decision was definite, her husband was not going to accompany her to this birth.

In 1993 at the T-1 hospital, I saw Lucia ask for a cesarean. She told me she was fed up with being *jugueteada* (the word "played with", a euphemism for all the vaginal checks she considered needless). This was her way of responding to the denigrating experience of giving birth publically (Good Maust 1995). A woman who gives birth in the Seguro is not known as a private client with expectations and rights, she is seen as a person receiving the benefit of public care, without a voice in the kind of care she wants. Even Berta, an administrative secretary from the "up and coming" neighborhoods in the northeast of Mérida described what she had been told about giving birth at the Seguro Social (IMSS).

> There are a lot of people who I work with who told me not to go give birth in the Seguro, because everyone is putting their hand in you, everybody there has to check your dilation, and there are a lot of interns. The specialist in charge also has to check you all the time to see how the baby is coming down, if there is still a lot of time left, and I don't know what all else, what I mean is. . . it is all in really bad taste, I tell you the truth, most of the women tell me about really bad experiences.
>
> Berta Rosado de Sandoval, Brisas, northeast Mérida

The arrangement of the labor and delivery room, and the positions women lie in, the presence of many people who prod and poke makes it possible for women to feel really vulnerable. In vaginal birth the woman participates: pushes, groans, demands, and screams. Emotionally, viscerally she is present in the moment of birth. A cesarean is different. A woman lies flat on a table, legs together, genitals invisible. The sexuality of giving birth is somewhat invisibilized. She is also imagined, due to the anesthesia and the presence of the curtain which separates her face and arms from the site of the cesarean, to be absent. Numerous women mentioned how hard it was to try to speak, to be present as a sentient mind, and engage the doctors in conversation during the operation.

> There I was, passing the time talking. "What else are you doing now?" "It is hurting me." He would answer, "It is not hurting you." He even told me to be quiet two times. He said, "Silence. Please. You make me nervous."
>
> Leticia Peraza de Montero, Jesus Carranza, north Central Mérida .

> It is truly the most horrible thing that has happened to me in my life. The anesthesiologist said that it was not possible for me to feel pain, it was simply not possible. But I felt something so painful it made me say my prayers to God. The anesthesiologist told me, "Just wait till your baby comes out, and I will give you something to sleep." I felt everything. When they cut me. Not so much the pain, at that moment, but the sensation of being cut. Where I did feel it was when they need to push the baby down, they have to move you. Because my cesarean was horizontal, they have to push the baby down to take it out. At that moment with the movement on my bladder. . . oh Holy God, I think only God. . . When I remember that moment, I just shiver. I felt how I was shaken by the doctor, and I told them, "It hurts me, it hurts." And he said, "How is it going to hurt you, that is impossible." "But it hurts doctor," I told him.

> The anesthesiologist told me later that sometimes the anesthesia doesn't reach into all those places, and you can feel the sensations. Don't you think that is so cruel? Especially since he wasn't feeling any of it. There I am shouting that, "It hurts me, it hurts me." And he said, "No. How is it going to hurt you?" And I say, "It hurts." And he says, "It is just your nerves." I tell you, I am not that crazy to be nervous. With my other children I was nervous and I never felt like it hurt me. So. . . it really impacted me. Even now, I try not to remember that. I try to remember the good parts and not the bad parts. But there was a very disagreeable component, and I think some of those doctors just have no sense of ethics. And I use the word ethics on purpose. They should put themselves in the place of the patient. There they are operating. Talking amongst themselves, and no one talked to me. Maybe it would have been different. They gave me oxygen, but I am so nervous that I couldn't stand it. I told them, "Take it off, take it off because I am going to suffocate. I feel like it is in my way," I said, "I am more tranquil without the oxygen." So they take it off me, and there they sit talking about fishing. Did you go fishing or didn't you go fishing? And there I was, all alone. Horrible. Horrible. The pediatrician who I am kind of able to talk with wasn't even there, he got held up somewhere. . . I felt alone the whole time. And when they do start talking, they start yelling, "Please, where is the suction, look at how this is filling up with blood here?" "They are going to say that we are pigs," and all kinds of other things. I think, "My God, how can they say these things, how can they do this." And there I am listening, it is really horrible. One is so nervous, and I know that their yelling is kind of like them playing, but I was nervous. I am thinking, what is happening to me? It is what you think when you go into an operation, you don't know what all can happen, and there they start talking about blood flowing over everything, and I couldn't help but think, "My God, please don't let me bleed to death." Well, no matter how much you study, no matter how much you prepare, when the time comes, you just agonize.
>
> Luisa Padilla de Mejilla, Brisas, northeast Mérida

Luisa, for the physicians in the room, was not a sentient, active being on the delivery table, even when she shouted, when she said dramatic and emphatic things about feeling, hearing, sensing the pain of the surgery. Her language was stripped from her because the physicians just could not imagine that she was mentally present, wishing to engage them in that way. They could talk about her body as if it were an non-sentient object, making fun of the dangers of bleeding, casually inserting discussion of her body into other informal conversations about fishing. Luisa even tries not to think about this time, not to put it into

words because it recalls for her a terror and horror she is reluctant to name. Her absence is made starkly clear because she wanted and needed so desperately to be present, to be heard, and because of the terrifying failure of the anesthesia to actually make it possible.

For some other women, and the physicians who attend them, when the anesthesia actually works the way it is supposed to, the possibility of being absent as a sentient being can be a comforting thought. One resident, studying her specialization in family medicine, said that many of her female colleagues, physicians in training, chose to give birth by cesarean because they don't want to give birth in front of their co-workers in the hospital. Is this because they are afraid of not performing courageously? Is it because the cesarean provides them a more absent place. . . a place devoid of the sexuality, of language, of feeling that runs under normal childbirth? Is it an escape from the truly denigrating conditions of giving birth in a labor and delivery room where the body becomes a machine marked by centimeters on a piece of paper, set within a set time frame, and lined up in a place of maximum efficiency, an assembly line you could say, for bringing babies into the world? Thought of in this way, the cesarean for some women "humanizes" the birth machine of the hospital by giving them an empty place, a silent place in the assembly line of childbirth.

Dr. Ferraez, one of the most critical and reflective physicians I interviewed, told me the narrative of a cesarean he did because he was convinced that it was the best for the woman in terms of the psychological trauma she had suffered both in her first pap exam in the village, and also the rape that led to the pregnancy. The young woman told him both stories, and asked him to consider giving her a cesarean saying that she was not interested, ever, in marriage or another child. He said that in a case like this, he considered the

programmed cesarean a justified response to the psychological trauma that has resulted in so much pain for her. This narrative is the clearest example that the cesarean was imagined in this case as a de-sexualized birth. It was what he could offer to help her not-remember the abuse and violence that she had already been subjected to.

This narrative contrasted so strongly with a similar but entirely different narrative about sexuality and a cesarean. The fact that the woman gave birth by cesarean was mentioned, in this case, as incidental to the larger narrative about sexuality in childbirth. Dra. Rivas mentioned how rewarding it is to work with patients one on one in the lowcost private sector. She mentions the following case as one of the reasons she continues to work with obstetrical patients. Her patient came by that evening specifically to thank her for the child, saying that it was a result of her counseling about helping her change from "nun" to a different expression of her sexuality, that she finally had her first child at age 42. I met this woman in the waiting room just as she was leaving the consulting room with her husband and her baby.

> This case of the woman (you just saw leave) she was one of these. It is a beautiful case because this woman is 42 years old. and it was very hard for her to get pregnant. She got married, but she didn't get pregnant and she was so afraid that the baby might be downs, imagine that fear, no? I really enjoyed being with her. We had to operate on her because she had a virus in the vagina and this baby could not be a normal birth. It had to be cesarean. It was a hard birth, but a beautiful birth. I enjoy my patients. You know what she said to me when she came in? "Look, this is the result of your psychology" she said. It is just that when she used to come to her check-ups, when I knew this girl she used to come all dressed just so, all covered up. She was a Miss Spinster, right? And that is how she would come. A classic. "There comes the girl, Stra. Limantour[2]," that is what the neighbors used to say I talked with her, talking the time away here with me, she slowly began to change. Then, we saw her in love. She has been

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[2] Señorita Limantour is metaphorical for a rather stiff, fastidiously dressed, 'proper' young lady who thinks a little too much of herself.

> She has been my patient for years, and she fell in love with this fellow and when she got married I went to her wedding. I have enjoyed her so much, and I went through all of this with her baby, and the suffering of both of them.
>
> Dra. Rivas, lowcost private clinic, center of Mérida

Aesthetics and Sexual Function

The previous section addressed the performance of the body during birth, and the discomfort that both women and their physicians can feel with the sexuality that underlies the process of giving birth which is somewhat invisibilized in the cesarean by absenting the woman from the process. This section addresses a second issue in sexuality and cesareans that has to do more with people's ideas about the physiology of sex. This issue is most often referred to as an issue of aesthetics, but it is really about vaginal function in heterosexual intercourse, and how giving birth affects a woman's ability to give and receive pleasure during sex. The underlying assumption is that giving birth by cesarean will preserve a certain virginal quality of elasticity and tightness in the vagina that giving birth vaginally will compromise.

A leading obstetrician at the prestigious Hospital de Perinatología in Mexico City gave a keynote address about cesareans to a Lamaze convention in 1997 (Kunhardt Rasch 1997). One of his points in defense of the cesarean, was that an "aesthetic scar" was preferable to a "damaged vagina," although he was also clear that he included cesareans done solely for the purpose of *estética pelvi-genital* (genital-pelvic aesthetics) among other dubiously justifiable reasons for cesareans such as legal problems, economic incentives, family pressure, and psychiatric reasons.

On two occasions I asked physicians in Mérida about this, curious if this was something that women would mention to them as being important to their consideration of

how they wanted to give birth. In the first case, I interviewed a medical couple who had just had their second cesarean. Mirna is a nurse planning to begin her M.A. specialization in surgical nursing. Her husband, Dr. Regil was a plastic surgeon who works primarily in reconstructive surgery (as opposed to cosmetic). I asked them to comment about Dr. Kundhart's comment about "estética pelvi-genital", to see if they thought a concern about "sexual fitness" was influencing people's decisions about cesarean, and whether this worries women to the point that they would request reconstructive surgery after vaginal birth. Dr. Regil explained, as a plastic surgeon himself, that I was confusing an issue of aesthetics with an issue of function. The vagina has two functions: coupling and childbirth, of which, he said, coupling is probably the primary function, this issue can not be dismissed as "aesthetics." This is probably part of a range of factors that pressure a private physician to give cesareans in his private practice. He buries this concern in a long list of non-medical influences on the desire for a cesarean.

> In private practice the obstetrician can let themselves be influenced by the opinion of family, by the opinion of the husband, by the mother. . . That she shouldn't suffer anymore, "Poor thing it is taking too long, Dr., please, can't you do something?" Or sometimes, the mother's attitudes, "Doctor, I don't want to feel a single pain." "Doctor, I don't want to be deformed." "Doctor, I don't want to have trouble with my husband after this birth, because of that I want a cesarean." "Doctor, I don't want this baby to suffer, I don't want there to be fetal suffering" . . .just like that there can be a whole series of factors that influence.
>
> Dr. Justo Regil, Residencial Pensiones, west Mérida

The second physician I asked works exclusively in private practice, unlike many physicians who work both in private practice and in the public hospitals. His cesarean rate is rumored to be among the highest in the city. Andrea, one of his patients, had told me not too long before that he had recommended a cesarean over a forceps birth, telling her that her baby was a bit too large for her pelvis and although it could be born normally, he

would probably need to use forceps. "He told me there would probably be tearing, and sexual satisfaction just wouldn't be the same afterwards. He was very discreet about this, but that is exactly what he said." Andrea said she had never heard that this could be a problem from her family or friends before he mentioned it.

I asked him what he thought about the idea that a vaginal birth could negatively impact future sexual pleasure. Had he seen cases of this?

> Many, many. Yes, there is something we didn't used to ask about. We ask the patient about urination, and (they say things like) "Yes, after Manuelito was born, my bladder came down and I have a real problem with leaking urine everywhere." I'm talking about young women. This is not about urinary incontinence of adult women. Young women, and always because it was a long drawn out birth. So we ask also about decrease in sexual satisfaction, and the woman comments about it, "Yes, doctor, I came for you to operate because there is no sexual satisfaction anymore. It hurts to have sex." There is pelvic congestion. This is from long births. (Marcia: "So women do say this to you?") Yes they mention it. Clearly, however, prompted by us.
>
> Dr. Marcos Medina Alcocer, corporate private care

The childbirth instructors who accompany young women to childbirth and stay with them throughout, even for the cesareans know what women worry about before, during and after the cesarean in ways that medical personnel busy with other details do not get a chance to hear. This is one of the cases of the obscure woman who wants a cesarean for a variety of aesthetic and pleasurable reasons (the mysterious third party woman who I never met in person in an interview, but often through the words of others).

> Many go in (to surgery) saying, "this is wonderful because I really couldn't do any more" (because they had a prolonged birth. . . because they already pushed a long time) And they see it as another resource, a good one, for her and her baby, no? And others see it as good because they don't want to go through labor. I have had the experience of women who are ten centimeters dilated and they don't want to push because they want a cesarean. They don't want to push because they are afraid of expulsion. I am not sure if this is because they don't want to open their vagina. . . or what. . . they just haven't assimilated very well that a baby can pass through a vagina. So they are afraid, they are afraid that the baby

> will pass through the vagina because they can't imagine it, it is not something that is in their mind. . . no. . . I am talking about. . . generally this is true in women who are really pampered in their homes, girls of very good social position. . . they have certain characteristics. . . And these kind are very rare but they are there. They really are there. There was even one who said, "Good, now my vagina will not get stretched. This is better because later I wouldn't be able to please my husband," which frankly, to me is a tremendously brainless thing to say, but oh well. . .
>
> Anita Luz Contreras, Childbirth Instructor, Centro Psico Profiláctico

The images of the damage that the birth canal sustains during birth is deeply embedded through discussions of sexuality, and the simple fear of being cut. If you have a choice of being cut, one young woman told me with a shiver, wouldn't you choose your abdomen? For Berta, the administrative secretary from the "up and coming" neighborhood in the northeast mentioned above, the cesarean is not really a "cut" like one would imagine an episiotomy.

> One of the advantages of a cesarean is that they don't cut you. That's right, they don't cut you. Being cut must be such a pain after a normal birth when you have to use the restroom. At least in a cesarean they don't do that to you. That little cut, you know, I forget what they call it. They don't do that to us in a cesarean.
>
> Berta Rosado de Sandoval, Brisas, northeast Mérida

To avoid this "damaged vagina" in the words of the obstetrician, is the ability to do an aesthetic scar. As reported in the popular press in early 2000, an obstetrician in New York was sued for carving his initials beside the cesarean incision on a woman's abdomen as if he considered his work an art form. Many of the doctors mention the invisibility of the scar to be one of the major advances that makes cesareans much less repugnant for women. Luz María, the young woman mentioned above who lives in the very elite and exclusive neighborhood of La Ceiba, eight miles north of Mérida said that what did it matter, in the end, where the cesarean scar would be.

> So this time, I had to live through a cesarean. It was typical, I suppose. There is the doctor, my husband Eduardo is there, I am here. . . he is filming everything (we have the video now). The scar is minimal, now they do it as if it was a little smile because they say if you put on a bikini, so you can't see anything. Really, in the end what is it going to matter to you? But the doctors are very proper and it was very low. That is why I have the famous little tummy now. They make it so low, it must be about 12 centimeters.
>
> Luz María Gallindo, La Ceiba, north of Mérida

In the following narrative segment, Nora tells me about her experience lying in her hospital bed after the cesarean worried about the outcome of the cesarean, wondering if it was necessary, thinking about her baby, and the doctor comes by to reassure her.

> They had given me a lot of anesthesia, because I was so agitated. I went to see the baby and all, and then later the anesthesiologist came by, an elderly man, and since I was a little calmer now, I asked him how it all went, no? He said everything was fine, the cesarean is now a very perfect cut that practically can not be seen. It is a transverse, horizontal cut, I mean very low, you can put a bikini on later, and you are relaxed now, perfect.
>
> Nora Padilla de Gongora, Francisco Montejo, northwest Merida

Luisa Padilla had two cesareans and two vaginal births, she was quoted above about the silent obstetricians during her birth. Her cousin sent me to her as an authority on both kinds of birth. Luisa lives in a middle class neighborhood in the northeast part of the city and works in a small school in the south where she struggles to learn Maya to communicate with the parents of the students she has, as both teacher and director of a small school. Her husband is a veterinarian, and also works at learning Maya. Luisa is currently working on her master's degree in education. She was convinced that vaginal birth was the better of the two when it came to the overall picture, but when she referred to the incision itself, the difference between the two kinds of birth is not as clear. The following is an answer to my question about physical changes that she noticed in both kinds of birth.

> The only physical changes that are still around until now is that my incision is horrible even if it is a bikini cut. I don't like the way it hangs there. You see the line and the tummy hangs a little there, but aside from that, I think it is all the same. The only thing you are left from the cesarean is that scar and what comes of that incision. The physical changes are all the same, I think, for the cesarean and for normal birth. The only problem is that you are cut. They cut me both times. Two times they cut me and it does really bother you a lot. It bothers a lot, and the first time a few stitches came out and oh. . it was a little uncomfortable. In both cases they had to cut me (episiotomy)
>
> Luisa Padilla de Mejía, Brisas, northeast Mérida

Her comment is like many physicians who say "What is the difference, a cut below or a cut above?" A woman really does not have the option of giving birth without surgical intervention. She also echoes the comment that various mothers gave me, that the cesarean scar leads to a particular type of abdominal "folding" that gives rise to the stereotypical *pancita* (an abdomen that creases and hangs over the scar) that women refer to, and over-shadows their pleasure in an "aesthetic" incision. It increasingly appears that this issue was more important to the doctors than for the women receiving the cesarean. The following were the words of a physician who planned her cesarean and was telling me how the experience went for her. You can hear in her narrative the multiple voices she embodies within her. . . both the obstetrician who knows how to do the aesthetic cut, and the mother who is concerned about the bigger picture.

> There I was talking in my cesarean. Dr. Martinez attended me, he is such a magnificent and tranquil person. So I said, "Hey Doctor, make that cut nice and low so that I can put my bikini back on." "Yes yes yes," he says, "don't you worry. This is going to be perfect." But it was all so frivolous. Now that I am here, make it little, make it low so you can't see it above the bikini, make sure it doesn't give me keloids Doctor. This that and the other. The last thing that we talked about was the baby.
>
> Dra. Katrina Barrios Cetina. Aleman, north central Mérida

Linking the issues of aesthetics and sexuality, therefore, is about many things: different kinds of scars; concerns over the degrading experience of giving birth naturally in

public hospitals; and concerns over being able to enjoy intimacy if there is indeed a loosening of the vaginal walls. It is also important to examine ways in which women use the cesarean experience in different ways to negotiate their return to sexual intimacy.

Negotiating Return to Intimacy with the Cesarean

Another way to think about sexuality and the cesarean is how women use images of the long recovery time to negotiate their return to a sexual relationship. Since there is a certain ambiguity in this. . . major surgery in the abdomen means a lot of suffering, but it is not actually the vagina that suffers as in a normal birth. There is also ambiguity with the cesarean as to when one is healed "outside" and what is happening "inside" with all the layers and layers of the abdomen that are sewed back together. Leticia mentions this worry about how the deep healing was going in her abdomen. . . As background information, she had mentioned earlier in the interview that she had her cesarean due to having a narrow pelvis, which is literally, according to medicine, that the pelvic outlet is too small for the baby's head circumference. As mentioned above, in popular usage the word "estrechez" can be used in a general to talk about narrow hips, narrow vaginal canal, and narrow pelvis. In Leticia's case, she has always experienced pain with intercourse, and associates the diagnosis of "estrechez" with that pain. When she contemplates returning to an active sex life, a series of factors are intertwined. Her personal sense of being attractive, her worry about getting pregnant again when they prefer using "natural methods," her concerns about painful intercourse, and her concern that she is not healed up inside.

> It seems like before, during the pregnancy, you have more desires, and as a couple you just get more tender because of the care that you are taking together. My husband still likes looking at me, according to him, I am more beautiful than before. But I think I look horrible, and I still feel terrible, and he still says I am fine, I am not fat, if I am patient this will go away, and he says my stretch marks are like tigers on my behind. He is so tender. But I don't know what I am like inside. I can't tell until I go to the doctor. I should go one of these days for a papanicolau and figure out what kind of birth control we are going to use: injections, pills, IUD, I don't think so. I like the natural method better. I would prefer waiting until everything regularizes, and that could be two, three, four months. . . so I tell him, wait, please wait. I hope it isn't as painful as it used to be, but we will see.
>
> Leticia Peraza de Montero, Jesús Carranza, north central Mérida

I had interviewed Berta, the administrative secretary from northeast Mérida mentioned in chapter three, days before I talked to Leticia. Berta used both the pregnancy and the cesarean as a way to avoid the sexual demands of marriage. This became increasingly apparent during her interview, also be cited in the following chapter about how the social body is negotiated in cesarean stories. Offhand, she mentions that the pregnancy was very nice except for a few problems. The following comment is from later in the interview when she mentions the drawbacks of a cesarean.

> All my pregnancy was really very nice, a little argument here and there with my husband. A few problems because since I got pregnant I didn't want to have sex with him. The doctor told me that up until the seventh month (it would be O.K.) but I said, "no way," from the third month on. That was it. No way. So this did cause some problems because husbands, you can imagine. I was happy in my work.
>
> You can't have sex again very soon with your husband if you had a cesarean. In contrast, with a normal birth you can. I think it is two months after a normal birth that you can have sex with your husband. If it is a cesarean, you have to wait three months.
>
> Berta Rosado, Brisas, northeast Mérida

Berta is taking on through this format a narrative form, in this way choosing the acceptable role of the mother who has the right to be more than a sexual object for her

husband. Her cesarean allows her to postpone the conflict that will cause for a little while longer. Flora comments about intimacy in the broader context of motherhood, using words very similar to Berta:

> One's life changes, it changes from day to night. There is a real big change in your life. Sometimes you finish your day so tired. You are leading the little ones, helping with homework, dealing with the school, taking care of the wash, the food. You get to 10:00 p.m., and all you want to do is sleep and not think about a single person more. This has caused some conflict in our intimate life as a couple, at least I feel this way. I am so tired, sometimes, and I say to him, "No, it really would be better tomorrow, some other day." Well, he gets upset, and we have an argument, we fight. That is the only source of contention between us. Yes, it is the only thing we ever fight about, and we just keep doing it. Yes, one changes. Your life changes completely.
>
> Flora Kumul, Inalhambrica, central Mérida

Contrast this perspective with that of Elisa, professional in a local business and long time feminist who associates vaginal birth with a lot of sexual dysfunction due to some of her mother's experiences. Since she goes into some detail about this, a large portion of her interview is included. She mentioned during another part of the interview that she has made it a point in her life to run "against cultural norms and enjoy pleasure for herself rather than pleasure for others." With this perspective, in contrast to the quote above, the cesarean gives a woman the ability to resume sexual intimacy sooner than the women who suffer due to episiotomies.

> I recommend a cesarean of course. It is quick, it is over, the baby doesn't mistreat you, you come out of the surgery impeccably, you are not all messed up. Those are my recommendations. In addition, I was afraid, my mother used to always say (she had so many natural births, you know, they had to operate and re-doing the vagina that was all closed and this caused all kinds of personal, sexual conflicts, no?). So when she went to the doctor and said, "Doctor, you left my vagina too closed up," and the doctor said, "well, we did that for your husband, but if you want us to operate again." And she said, "No, I prefer burying my sexuality to going through another operation, because the operation is too troublesome." Everything turned out O.K. for her, but imagine that, you don't want that to happen again, no?

So this is the idea I always had, no? That sexual relations were less pleasurable, and always in function of the other, no? My own pleasure no longer exists. It doesn't exist. Pleasure doesn't exist or I mean I am telling you about the image that we had, no? It was in general understood that birth made the vagina flaccid, and your husband would no longer have the same sensation of pleasure as if you had a vagina that was well closed. Closed, closed the whole way (*laughing*). . . no I don't mean anything by that. Closed. Anyway, you come out like a virgin after giving birth. People, other friends, a cousin and a friend, have had episiotomies. I know they open up so many centimeters that way, but their skin was also torn and kind of flowered open, and the recovery was much more difficult than what I had with my cesarean. They had to sit sideways. . . on those little cushions like tires, so it wouldn't hurt so much.

I really had that idea that it was another disadvantage to a normal birth. According to me, this meant that you couldn't have sex for such a long time. You are all hurt. Even when you are pregnant you avoid sexual relations because the secretions give you this sensation that if you are pregnant you could get infections, etc. so you avoid it. Then on top of that, you have a birth where you are all episiotomized . . . That word, I am not sure how you say it. . . its clear that having an episiotomy means that recovery is slower for sexual relations, no? . . . that instead of 40 days it would take longer (because of the episiotomy) and on top of that the stitches and the flaccidity. I thought that normal birth was all about complications. In contrast, a cesarean is a manageable, programmable risk.

Elisa Vallegran Modena, Pensiones, northwest Mérida

Up to this point in the chapter, the issues that cesareans raise about sexuality appear almost trivial. The term "estética pelvi-genital" is very rarely used. Whether or not a scar is done perfectly, whether or not the idea of vaginal stretching is actually a problem for women all appears ambiguous, a conversation on the edges of the cesarean and somewhat suppressed. The way a woman negotiates her own feelings about returning to sexual intimacy in a setting where she obviously has some of the right to choose.

This is not always the case however, all the voices so far are of privileged women who consider the aesthetic scar an accepted part of a cesarean. For women who give birth at the public hospitals, this can not be taken for granted. While it was never a formal question, most women interviewed told me how their cesarean was cut. Generally, the women who gave birth in the public institutions had horizontal incisions only when they

had relatives inside looking after them, the overwhelming number of them had vertical incisions. In contrast, not one of the women interviewed who went to a private clinic had a vertical incision.

Ethnicity/poverty and Sexuality

Physician's images of how women at different points in the landscape of privilege and ethnicity feel about their sexuality and the aesthetics of cesarean are inscribed daily on the bodies of women who give birth by cesarean in Mérida's hospitals. In private hospitals, as shown above, whether or not the woman herself feels like it is important, a great deal of attention is paid to how the cesarean scar is placed and healed, always stated as a way that she can still appear on the beach in a bikini. Dr. Carillo, the director of reproductive health for Servicios de Salud says it is a matter of medical efficiency and better healing to do the vertical incisions which, he stated, are unapologetically the norm in the O'Horán hospital. He thinks that catering to the idea of aesthetic scars is just another example of the perversion of medical research by the consumer oriented private medicine. Regardless of the reasons, most women who give birth in the IMSS and in the Servicios de Salud hospitals get vertical scars, and women who give birth in private hospitals and clinics get bikini cuts. A medical resident at the O'Horán explained that both of the operations are the "Kerr" type of operation (over 95% at the O'Horán), where the internal incision is horizontal, but the incision on the abdomen is often vertical.[3]

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[3] Dr. Aristeo Maldonado. Resident, O'Horán. Wrote his thesis of specialization on the reasons for the high rates of cesareans in the O'Horán hospital. Available only at the Medical Library. One of the consequences of this, pointed out to me by Dr. Sharleen Simpson in reference to her experiences at Shands hospital in Gainesville, is that when these women migrate

In the struggle of the north American and European natural childbirth movements, images of indigenous and "natural" births are often drawn from pictures and drawings in anthropological and traveler accounts. Romalis points out how childbirth in other cultures is often romanticized (Romalis 1981). These romanticized images of what birth would be like untainted by civilization and technology are useful in their "distance" from actual use, both literally and figuratively. One of the most extreme of these cases is Pithiviers in France where Michel Odent runs the ideal birth center in terms of non-interventionist procedures. He claims that stimulation of a woman's neocortex (that part of the human brain which he claims differentiates humans from animals) makes birth longer, more difficult, and more painful. This stimulation occurs with light, or "by having to listen to people talking logically and rationally." He therefore advocates quiet, privacy and dark for birth in a "post-electronic age," where women can give birth with the "archaic brain" which governs emotions and instincts (Odent 1992:55-56). Ortner refers to this position as seeing birthing women as moving back in time and down the evolutionary tree to a simpler, animal-like, unselfconscious state (Ortner 1996:160).

These images are not as distant in Yucatán. Promoting midwifery among upper and middle class women is barely imaginable. But these images of "natural birth" are also used in Mérida, with different ramifications.

> Women from the village, autochthonous from here, give birth more naturally. They can put up better with birth pains. Even if they always scream and cry with the pain, they see it as something normal.
>
> Dr. Abraham Estrada, corporate private care, interview notes

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to the U.S. and go for subsequent birth to U.S. hospitals, cesareans must be scheduled due to the vertical scar - VBACS are only done on Kerr incisions. Since there are no medical records, it is impossible to know how the internal incision was made.

A contradictory form that the shaping of sexuality takes on is through the lens of ethnicity. Two contradictory notions are mentioned above: the "indigenous" woman as sexually pure and morally upright (guardian of the old and true values), which is interwoven with the notion that the "indigenous" is a place where the natural, chaotic and untamed nature of sexuality is rampant. A place where homosexuals are lovingly accepted as a natural part of the community, and daughters pick up on sexual services to their fathers and grandfathers when their mothers and grandmothers cannot.

Juana Gutierrez is a powerful businesswoman in Mérida society who traces her own lineages through Lebanese descent. She mentioned several "anecdotes" about helping impoverished or indigenous women give birth, reflecting that "those people" just give birth in caves, or with no shame surrounded by family members.

> In my time there was the *cuarentena* (forty day recovery period postpartum), and you would abstain from sexual relations for 40 days after birth, isn't it like that? I don't know how it is. I don't know how it is, I have never had the nerve to ask anyone, and I am not interested, but you, as an investigator. . you are interested in finding out, not? I guess we could check around here, how it is done now. There used to be men who were aware of their responsibilities, but then, there were men who were not. They would say to their wives, "if you don't, I'll go to the street," and that is why there are so many problems with bleeding and post-partum problems. Savages. And this happens more than anywhere else in the rural areas. In the villages this happens a lot, and if the mother can't attend him, then it is the daughter's job. Even that.
>
> Juana Gutierrez Sauri, San Miguel Aleman, northeast Mérida

Another way these images are maintained in Yucatán is the image of the Maya of the peninsula as being modest, courteous, and untouched by the liberalization of sexual mores. As Wilson (1995) sets out to show, neither of these images are consistent with everyday life in Yucatán. The anthropological record on sexuality is slim, and this also holds true for studies among the Maya, but it is also true that linguists and ethnographers who have

learned the language have found out "more about the texture of sexual life than other outsiders have been able to glean" (p.121). In the Yucatec Maya language, the sexual joking, double-plays on words and humorous expressions reveal rich images of sexual nuances in speech. Adult conversation is filled with sexual imagery and joking. "Flowing all in Maya, seldom overheard by outsiders, sexual talk is one element of what continues as the secret life of the society" (Wilson 1995:121). This has been noted by a variety of anthropologists in the Yucatán (for example: Burns 1983, Elmendorf 1985:96, Sullivan 1989:41-42, Wilson 1995). Other researchers refer to the frank, open and teasing way that Maya women speak about sex (Sullivan 1989:41-42[4], Smith 1983). Linguistically, the Maya language has a rich vocabulary for discussing sexuality and sexual topics.

This is not the image of Maya sexuality that health authorities may want to subscribe to in Yucatán. In the summer of 1995, a medical anthropologist in Yucatán specializing in reproductive health showed me some leaflets that deal with family planning methods and other reproductive issues. They are written as comic books designed to capture the attention of young people with stories. When the pamphlets were ready for distribution, they were removed from circulation because health authorities claimed that these pamphlets would encourage promiscuity[5]. In their images of indigenous life, women are modest, retiring and would be embarrassed by the material in the pamphlets. The aim of prevention programs should be to strengthen the family in a time of migration and

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[4] "Field Notes. Alfonso Villa Rojas. Quintana Roo Trip, December, 1932, Preliminary Notes" Dec. 12 and Dec. 19, 1932, and Jan. 3, 1933, cited in Sullivan 1989:41-42.

[5] Miguel Güémez Pineda, personal communication.

economic disintegration, not to provide materials which would give people ideas of the sexual degeneracy common in the cities and in so-called "civilization."

This is also expressed in the imagery that struggles to put the indigenous woman giving birth "naturally" farther back on the evolutionary scale, something from which the human race has progressed. A physician who teaches in the College of Medicine in Mérida, and who also works for a Feminist NGO that gives sexuality workshops for young people in Mérida, told me that she has heard the comment from young residents on various occasions that they were not going to "let their wives give birth like animals" and arranged for cesareans at the hospitals where they worked[6]. The difference between an image of a woman grunting, sweating, and pushing her baby out is juxtaposed with the image of laying on a metal table, calm, under anesthesia which is less "animal-like." This is expressed in many ways:

> In the O'Horán we have people who arrive in complicated conditions, "manejadas" by midwives or who do not go to their prenatal control, well, these simply don't know anything, they are at zero, very complicated and it is all the same to them if their child dies or if they die, there is no conscience. They have no education, and anything you do is fine with them. Now on another level (private practice), it is like I tell you, women and their husbands have a lot more information about birth. The husbands often come, and they talk a lot each month, they hardly ever miss their monthly "control," they ask you a lot of questions.
>
> Dra. Jacquelín Echanove Dávila, Ob-Gyn, private practice in the north

Dr. Rosita Alvarez has her office close to the market so that women coming in from villages find her accessible. I asked her if issues of sexuality would influence a women's fears or desires for a successful birth. She said that issues about aesthetics or sexuality were not pertinent for her clients, who are mostly indigenous from surrounding villages.

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[6] Dra. Maria Luisa Rojas. Medical school faculty. Personal communication.

The answer to that question, she said, would be easier in an interview with her husband who works at one of the most private clinics of Mérida. In that clinic, she claimed, are a whole range of "non-medical" reasons. Previously another physician who deals with the same population had mentioned that some women request a cesarean at the same time as sterilization, so as not to have to go through two separate recovery periods. When I asked her if women talked to her about their worries about sexual intimacy after cesareans she said simply that the people she attends were "from the village, and you know that village women don't worry about things like that." These images are crystallized to the degree that they become farcical, giving them a surreal cast when they are drawn into someone's narrative. At the same time, these notions have their material repercussions. That doctors feel this way about village women is inscribed on their patient's bodies daily in Mérida hospitals in the way they choose to operate.

For several of the women interviewed, the issue of how their cesarean scar healed was traumatic enough of an issue to bring up into the narrative of their cesarean, and several showed me scars from their cesareans. Marta Jimenez is one example. She lives in south Mérida, and her husband worked at the major newspaper in town. She had put quite a bit of effort into decorating their home, one of the very nicest houses in the neighborhood. She had her babies over 15 years prior, and still remembers the care of her operation as a matter of neglect by the hospital.

> In the private clinics they are more careful than they are in the Seguro, where they don't take very good care of you, not as much anyway. I think that is the reasons for what happened to me, that is what I think. Not enough time had passed before they took my stitches out and that is why it opened up, my incision was still new. Oh well. What happened to me is what happened. That is what I thought. I said to myself it must be because they took them out too soon, because when they took them out it hurt so much. It burned a lot, and then when they

> released me and I came home, again, it was the saddest Valentine's day I've had. My incision was long, like this (*she shows me)* horrible. It is horrible, isn't it? I don't like it, it makes me ashamed to have my husband see me. He says to me, "how can you be ashamed of it is your son was born there, it is beautiful." But I feel bad because they pulled and tightened so much that my stomach ended up all ugly. So ugly.
>
> Marta Esperanza Jimenez, Melitón Salazar, south Mérida

Conclusion

A vaginal birth is also a hospital birth with very little "natural" or "normal" about it regardless of the terms commonly used to describe non-cesarean birth. In medical language, terms *parto* (birth) and *cesárea* are often counterposed to each other - where the term *parto* refers strictly to a vaginal birth. Recently, more physicians use the terms *parto vaginal* (vaginal birth) or *parto abdominal* (abdominal birth) demonstrating the increasing medical acceptance cesareans as childbirth rather than being seen primarily as a surgical intervention. In popular terms, women often refer to a non-cesarean as "normal" regardless of how many interventions such as forceps, epidurals, etc. are involved. In the hospital, women are hooked up to pitocin (a contraction producing drug) on a regular basis; going through the routines of shaving, prepping, enemas; episiotomies considered routine; regular checking of dilation and charting the birth on the *partograma*; the making prone in a hospital bed due to logistics as well as any other reasons; even the possibilities of epidurals which for many women in private hospitals are now routine[7]. The shifts in perspectives over what constitutes birth are part of cultural patterns available for

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[7] In public hospitals, epidurals are saved for those women perceived as less likely to be able to stand the pains of childbirth. I have been told by both physicians and nurses that they are more likely to be needed for first time mothers, and also for the city women (often interpreted as whiter women) who are not used to the rigors of country living.

negotiation what it means to have a woman's body, become a mother. Struggles over what is "natural" and what is "technological" are also lens through which people construct patterns out of social landscapes.

Hospital forms of childbirth are developed within deeply gendered ideological frames of reference for medicine and reproductive care, and is not "natural" childbirth. It is part of a way of societal ways of thinking about the female body and sexuality. As such, both vaginal births and cesareans have to also be examined in terms of sexuality and how those images are again refracted through issues of ethnicity and class.

CHAPTER SIX
DISCUSSION AND CONCLUSIONS

The primary question addressed in this dissertation is how the local epidemiological patterns in cesareans are understood, contested and given meaning in the narratives that women and physicians tell about their experiences. In Mérida, as in many other parts of Mexico and Latin America, women in the private sector receive many more cesareans than women who go for either kind of public care. There is a direct but inverse correlation between the degree of economic and social privilege and the cesarean rate. The paradox embedded in these epidemiological patterns is that women at the supposed highest "risk" receive the least degree of surgical intervention. The cesarean then becomes, in everyday life, a marker of social privilege, a way that people use to talk about social difference in its many patterns: ethnicity, class, race, sexuality, gender. The cesarean is undoubtably the medicalization of childbirth, one of the outcomes of the institutionalization of the time, space and relationships around childbirth. The other side of this story, however, is the socialization of the cesarean: how it becomes interpreted and used symbolically in everyday life.

During a study in 1993 on urban midwifery, I found that midwives and their clients in south Mérida are convinced that *delicadas* (delicate), (a sort of euphemism for the type of women who have allowed themselves to become fragile, dependent and soft because they are wealthy), had to have their babies cut out of them in the hospitals. In contrast, women

who know the rigors of life with poverty and work hard with fortitude and determination to confront their circumstances are the *valientas* (courageous) who are able to birth their babies with strength and courage and without the need for surgical intervention. In this way, the epidemiological patterns in cesarean rates are given social meaning, and women are defined in degrees of moral strength, courage, determination and physical resilience according to their position in society. These patterns were one sort of explanation for the cesareans in the south of Merida in midwife homes. Another kind of explanation is about the unscrupulous and corrupt physicians who care more about saving time and making money than they do about the art of the profession of obstetrics. Looked at this way, midwifery was being redefined as a place where women can contest the oppression of a corrupt medical structure by providing women with a space that they could evade the surgical interventions seen as almost inevitable in hospitals.

Given the presence of these social meanings around the cesarean, this larger study was designed to cover different points in the social landscape of Mérida and examine the personal narratives that the "corrupt" physicians, the re-defined midwives, and most of all, the women who are considered the "*valientas*" and the "*delicadas*" give to their experiences. I was primarily interested in how women in different parts of the social landscape would confront the various institutional forms of a hegemonic medical system.

Urban Ethnography and Social Imaginaries

The first chapter, in addition to defining how the way social body is defined for this research, describes the social landscape of Mérida within which the relationships in and between social bodies are negotiated. This narratives told in the interviews all are situated

within this urban setting, and are set within the patterns of identity and hybridity that are shaped by the physical and social mapping of the city. The narratives are part of an urban ethnography, and as such require and understanding of the negotiations of social imaginaries throughout the geography of the city.

It is particularly troublesome, thinking about the diversity and the negotiations in all the social spaces of Merida, to write, as in the first part of these conclusions, about "women" in a general sense and about "narrative" as a pattern of telling a narrative that cross-cuts the social landscape. One of the crucial elements of this research was to do an urban ethnography that takes into account the different social imaginaries that overlay the urban setting and shape the experiences of women in different parts of the society and in different relationships formed by the many intersecting patterns of ethnicity, poverty and wealth. It is important to examine the narratives that people tell about cesareans not only within the context of family and the creation of social bodies, but in the many ways that people find to position themselves in the webs of social relationships. Narratives can not be read flatly, as if they have a general meaning that is commonly understood. For example, giving birth in the Seguro Social for women in one part of the social landscape of Mérida is a matter of access to privilege: one is linked into a mode of production in which the state "owes" one the privilege of technological resources and medical care. For these women, narratives of cesarean in the Seguro is a mark of privilege, even if they also pay for private medical consultations on the side to make sure that the care they receive in the Seguro is adequate. For women in a wealthier segment of the social landscape giving birth at the Seguro Social means that one does not have access to the necessary resources to pay for private care and must settle for the basic resources provided by the State. The

same narrative of "giving birth at the Seguro Social" means entirely different things to women in different relationship to that "privilege". In this way, attention to the social imaginaries of how health, wealth and ethnicity are patterned in the city is crucial to a reading of the narratives in the first place. Social body does not always mean the same thing, and narratives are situated in different ways against those patterns.

A second issue addressed in this urban ethnography is about studies of reproductive technologies within the context of the stratified nature of reproduction (Ginsburg and Rapp 1995). People's lives and the meaning of reproduction, both social and physical, are being redefined by the relationship to medical interventions. The most interest is often paid to the highest technology used, to the most evocative, cutting edge, or controversial elements of reproductive technologies. I would argue that in order to understand the social patterning often found in the distribution, use and abuse of these technologies it is most important to use an "old" technology, the cesarean with a long history. There is no part of Mérida, or even Yucatecan society, which is untouched by the cesarean. People across the many social spectrums live with the knowledge that babies are often born with surgical intervention. In this way, the social patterning of those interventions is available for study even among the least economically and socially privileged populations. In the anthropology of reproduction, more attention needs to be paid to how reproductive technologies are distributed and given meaning, not only among the privileged but across the social landscape.

A third element of an urban ethnography is to consider the social fields that overlap in the city. I mentioned above the need to understand the different social imaginaries created around and overlapping in the distribution of medical resources. In this ethnographic

study of cesareans it was important to consider the imaginaries created by patterns of economic privilege, and ethnic mappings. It was also important to imagine the social fields of midwifery and hospital/clinic resources as overlapping. It is important not only to look for difference, but in the ways that people creatively and many times simultaneously negotiate a variety of imaginaries.

One last point about urban ethnography. In addition to considering the urban ethnographic field of childbirth as including both medical and midwifery settings, it is also important to consider how local intellectuals describe and give meaning to these processes. As such, I considered the seminar I was involved in with other Yucatecan researchers, physicians, social scientists and feminist activists as a part of the urban ethnographic experience as well. To experience, as a participant observer, the local intellectual and activist stances and definitions of the questions that should be pursued, and to continually examine the patterns that shape the ways we create those questions is crucial to an anthropological study of urban space.

Narratives and the Anthropology of Power

Chapter two is about the narratives told in the epidemiology of cesareans: narratives about the larger context of the local, national and international epidemiological patterns of cesareans. This context is a part of the scenario against which women and physician's narrate their own experiences. This chapter also addresses the way in which the local meanings of cesarean require a shift in how power is imagined and framed in anthropological research: the way that anthropology has addressed the ways in which people create and are created by structures that shape meaning and cultural patterns.

Cesareans are a part of fundamental change in childbearing patterns across the world. High(er) technology obstetrics is increasingly available in many places, including the most remote areas at the same time that natural childbirth and midwifery movements bring a nostalgia and longing to return to a more "natural" form of birth to women in the industrialized countries. How does anthropology, with an enduring interest in the "small" side of structures, confront the multiple meanings that criss-cross in everyday life as these global processes become locally lived and experienced? How do we think about creativity and meaning for people inside of global structures? What does it mean for anthropology to imagine power and analyze both macro and micro processes at the same time?

There are pressures to understand these global processes in two ways. First of all, to see a sort of cultural flattening of difference in the globalization of economic processes, in patterns of consumption which are increasingly shared, and in communications systems through the media which supply ever-more common metaphors and imaginaries to people in all parts of the globe. Cesareans are designed and taught in medical school curriculums from texts shared internationally, conducted with technology that is mass produced and mass consumed in hospitals across the world and even portrayed on movies and soap operas with broad audiences. Ideas about the timing and spacing of birth, the patterns in the stages of labor, the ways that "appropriate" physiological steps are mapped out and applied in ever-increasingly global scope on women's bodies without consideration for possible biological, social and cultural differences. Health policies are mapped by international health agencies and taken up by national agencies and applied to diverse populations. In Mexico, as in other parts of the world and Latin America, there is an office of "normativity," and the national health system has a book called, "Norma

Mexicana," in which efforts are made to bring statistical and epidemiological evidence into patterns considered normal for the whole population. Within reproductive health, high cesarean levels need to be flattened, maternal and infant mortality must go down, abortion levels must be curbed, and women's use of obstetrical services and fertility control must increase to bring Mexico within patterns of well-being that are internationally acceptable. In what ways does this mean the state and international agencies are an instrument of power that shapes local populations and flattens difference?

On the other hand, there is increasing interest in the multiplicity of responses possible to structures described in different ways as powerful (e.g. hegemonic, dominant, controlling processes). Inter-disciplinary curiosity is increasing exponentially, it seems, in the ways that people involve themselves in a variety of ways to supporting, sustaining, and shaping these structures around themselves in varying degrees of making them "fit" local needs. How do we look at medicalization without creating victimologies which are ultimately not very useful for understanding how people negotiate and create the meanings that are pivotal to the inter-related side of physical and social survival? It is not enough to examine structures as hegemonic, as dominant, without examining the ways in which people bring those structures into existence. What is the form of the structures and how are they negotiated by the people in them. Anthropology is particularly well situated, with its enduring interest in symbols and stories, ritual and everyday cultural patterns and meaning to look at the multiplicity of answers to those questions.

Narrative as Labor in Social Reproduction

My original intent, as a researcher influenced by the academic and popular sides of the Women's Health Movement in the U.S., was to hear either resistance and creative strategies into the ways women employ to confront this exertion of structural power in the moment of giving birth. How did women frame their desires about childbirth: in resistance to, or from a position of acquiring, manipulating, or coopting medical resources? However, throughout the interviews, I found that while people understand that physicians rely too heavily on cesareans, and in general, women did not want the cesareans that they ended up with, they did not choose to narrate their experiences of cesarean as resistance against a hegemonic medical system or against the physicians that embody that hegemony.

Chapter Three addresses how narratives about birth are a form of labor in a system of social reproduction: a tool for the shaping and creation of social bodies. Through cesarean narratives, women demonstrate the competence to assume the position of mother in the wider social body. They do this demonstrating through the way they narrate their experiences: selecting out and emphasizing their use of social and economic resources: the people who gave time and labor during the long period of recovery that is necessary in cesareans; and the degree of medical technology, and financial resources expended on their behalf.

This understanding of narratives as a form of labor in a system of social change and reproduction must be understood within the context of the Mexican economy. As mothers, many women are responsible for the shaping and maintenance of social bodies that are crucial to everyday survival. Distribution of resources happens not only through

people's positions in the mode of production, but also through their ability to negotiate the webs of social relationships that are formed to actively negotiate and make liveable a system of huge economic inequities. The bulk of capital and resources are concentrated in a small part of the population, but all kinds of social alliances exist (primarily through political and familial bodies) to redistribute that wealth and ensure the everyday survival of much larger part of the population. Women, in their positions as mothers, are in a particularly crucial point of these negotiations. Through childbirth, women physically become mothers, but they also take on a societal position of making and maintaining social bodies. Childbirth is a moment to study physical reproduction, but also social reproduction and societal change. This process appeared to be far more crucial than the need to confront an abusive medical model which relies too heavily on cesareans. Abu-Lughod (1990) points out the need to look at power, not only "down" through oppressive systems, but through points of everyday resistance. In this research, it appeared that women were far more interested in resisting meta-narratives which frame women who give birth by cesareans as weak, fragile and afraid of pain: which is a narrative that detracts from their abilities to deal competently with the creation and maintenance of social bodies. Women showed through their cesarean narratives that; 1) they indeed suffered greatly (and consequently deserve the moral authority that is gained through childbirth pain), 2) that many people invested time and labor in helping them through both the trauma of surgery and recovery (demonstrating that they have adequate social networks), and 3) that financial resources were spent on their behalf (indicating they have access to the economic resources in times of emergency that ensure familial survival). In

this way, women showed through their narrative labor that they are indeed competent to negotiate the complicated webs of family and society.

The Body: Shifting Images

The cesarean has developed, in part, out of philosophical shifts in the cultural shaping of medicine and the ways that the body is imagined as a machine within a factory mode of reproduction (Martin 1987). The space of childbirth, the people within that space, issues of hygiene and risk, and the way that time is imagined and managed in an institutional setting have all contributed to an increasing reliance on the cesarean as an efficient, timely and safe means to deal the ways in which the physiological patterns of childbearing unfold in a hospital setting. In chapters four and five, I describe two elements of the ways in which images of the body shift around the cesarean and its increased usage. The first, about the pregnant and birthing mother-baby body, is primarily a story about how images of the child within have changed. The second, about the making and un-making of sexuality, is more about how the site of surgery on the mother's body activates all kinds of discourse about motherhood, virginity, ethnicity and pain. This disturbance of normative images of childbirth throws into relief several aspects about sexuality - including aesthetics and ethnicity.

The Child Within

Chapter four is about the mother-baby body and shifts in the way it is imagined, but it is primarily a story about the child within and changing images of what it is expected to do. Narratives about cesareans are often framed in terms of childbirth as a cooperative

endeavor between a mother and the child within. When the child can not contribute energy and strength to the process, childbirth breaks down and the mother must resort to a cesarean. This way of thinking about the mother-baby body put the responsibility for a successful childbirth on both the mother and the baby. Failure could be framed either by a mother *"que no pone de su parte"* (who does not do her part) by energetic pushing, or by the failure of a child to struggle through the birth canal. Many women will frame their need for a cesarean as the fault of the child who did not have the strength to be born, and cite hospital personnel as giving this as the reason. In this way, an old way of imagining the baby is brought with current obstetrical reasoning.

Most physicians, however, in interviews with me, referred to the mother-baby body as a *binómio*, and the child is considered an important entity in terms of rescuing it from the ravages and potential dangers of traveling through the birth canal. The potential dangers, within current society where intellectual development is crucial to a productive member of society, are framed around concerns for the brain. The brain can be damaged through oxygen deprivation, through the physical trauma of negotiating the birth canal, or through hazardous technology such as forceps which can leave bruises and damaged skulls. The cesarean is a solution to all three concerns: the child is removed quickly - therefore eliminating concerns about oxygen deprivation; the birth canal is not navigated - leaving the head of the child untouched; and no instruments touch the baby's head.

Another way in which images of the child within have changed are in terms of levels of physical stress. In some narratives, mostly from midwives and midwife clients, a child which is energetic, pushing and lively 'helps' the mother through childbirth. In contrast, many physicians, mothers and family members expressed a lot of concern about undue

stress on the child to be born. A baby which is born through the abdomen is free of physical markings of struggle, many point out that it appears to be several months old, tranquil, and beautiful. The director of a childbirth education center in north Mérida pointed out that a study needs to be done from a pediatric point of view. With the increased specialization of roles in childbirth, both mothers and the obstetricians are removed from the scene of pediatricians vigorously massaging cesarean newborns who have not had the physical stimulation that a struggle through the birth canal provides for newborns. Both women, and their physicians only see clear skin and tranquility.

Motherhood and Sexuality

Chapter five addresses four issues of sex and sexuality that emerged from the interviews. 1) the cesarean as a way to de-sexualize the experience of giving birth, 2) issues of aesthetics and sexual function 3) how women use the surgical procedure to negotiate the terms of their return to sexual intimacy, and 4) issues of sexuality and ethnicity that are made visible through the types of incisions that physicians use on women's bodies.

The institutionalization of childbirth removes some of the privacy that women had and expected. Many women are birthing at once, and personnel must attend various women at the same time. The lithotomy position, and the variety of students and other medical personnel which pass by with different kinds of intervention, bring a degree of exposure that is uncomfortable for many women. The cesarean, in contrast, is private and the position does not require as much genital exposure. The sexuality of birth is somewhat invisibilized - the woman is anesthetized and a curtain separates her from the operation.

Secondly, in contrast to the way the baby is protected from brain damage through passage through the birth canal, the woman is also seen to benefit from a cesarean in that the vaginal canal is not stretched and damage by the passage of the baby. "An aesthetic scar," says an major obstetrician in Mexico city, "is preferable to a damaged vagina". In this section, concerns about recuperating from the pain of episiotomies is also a concern for several women. If one has a choice between "a cut above" and a "cut below" - what is the difference - especially if through a cesarean a woman is imagined to maintain her vagina in a virginal state.

Thirdly, women use their narratives about cesareans and their experience of surgery to negotiate the terms of their return to sexual intimacy in different ways. Different kinds of pain can be emphasized, depending on her own desires. In one way, the cesarean, because it is abdominal and birth does not take place through the vagina - is seen as a speedy recovery making possible a quick return to intimacy. In contrast, other women emphasize the severe pain of abdominal surgery and the many internal layers that take months to re-knit. Some women refer to having had children by cesarean as a way of preserving their sexual desireablity.

Lastly, Michie and Cahn point out how the cesarean activates all kinds of ambivalence about normative gender ideals and natural childbirth. In Mexico, these images are closely tied to the distance between a rural and indigenous image of "nature" and the technological resources more available to the cosmopolitan, urban and privileged populations. Ideals about motherhood and sexuality are inscribed differently on mothers in different segments of the population. In private hospitals, cesareans are done with horizontal incisions, carefully placed as far below the 'bikini line' as possible. One of the

marks of a successful cesarean in private care is its invisibility on the mother's body. In contrast, in public hospitals where efficiency takes precedence over aesthetics, and most frequently surgery is done by medical students, cesareans are most often done with vertical incisions. Some physicians will even say that the aesthetics of an un-marked abdomen are not important to indigenous or poor women.

In these four ways, women and their physicians inscribe gendered and ethnic meanings on the moment of the cesareans that goes far beyond cesareans as an emergency medical procedure. These meanings are not monolithic, but struggled with, contested, or coopted in different ways by women and physicians in different parts of the city.

Conclusions

The cesarean is a worldwide medical phenomenon which has certain epidemiological patterns in common across regions and nation states, and develops in unique ways in others. This ethnographic urban study takes an anthropological approach to examine cesarean narratives and the ways that local meaning is created around this medical event: in a sense examining the 'socialization' of cesareans, rather than the "medicalization" of childbirth.

At one level, this approach can show how the epidemiological narratives in the numbers are both embodied by physicians and inscribed on women who give birth. This can illustrate the hegemonic nature of medicalization and how the state reproduces culturally patterned reproductive bodies that follow international patterns of how to best create docile and productive citizens. This study has shown how class and ethnic differences are mapped on women's bodies, and how women and their physicians lean on

cesareans to produce babies perceived to be mentally and intellectually competent to be productive members of a society in which mental labor is valued over physical.

However, these epidemiological narratives of cesarean rates are lived, shaped, and retold in the narratives of those who experience the cesareans themselves. I have found it useful to imagine the power that is exerted and expended in the medical encounter as a sort of narrative fuel that women and their physicians can use to create webs of meaning and social relationships either in relationship to medicine, but more often in non-medical arenas. In this way, medical power is coopted, interpreted and transformed into shapes of influence that can be used effectively in other arenas of life. By suggesting that narrative is a tool that women use to create social bodies is not to diminish the ways in which bodies and cesareans are part of hegemonic patterns of health policy which are designed to create reproductive bodies that fit the needs of the state, but that the same patterns can be bent and twisted and transformed through narrative to address hegemony in other areas of life that are perhaps considered more important than struggling against a medical system which is understood to embody progress and modernity. Narrative is a way in which women use their experiences of cesarean to address issues important to the bodies of mothers and babies, sexuality and ideals of motherhood. In this way, the narratives shape a social body, a body which struggles for either the continuity or change that is necessary for negotiating the ruptures and economic crisis which are a part of everyday life in Mexico.

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BIOGRAPHICAL SKETCH

Marcia Good Maust is a doctoral candidate in the cultural anthropology program of the Anthropology Department of the University of Florida, with an interdisciplinary emphasis in Health, and a Ph.D concentration in Women's Studies and Gender Research. She received her M.A. in Latin American Studies from the Center for Latin American Studies at University of Florida in 1995 with the thesis "Childbirth Conversations in Mérida, Yucatán." In 1980 she received a B.A. in Social Work from Eastern Mennonite University. During the 1980s she worked for two years in Miami, Florida with Cuban and Haitian refugees, and six years in Santa Cruz, Bolivia in adult literacy and appropriate technology. During her dissertation research and write-up she was a Profesora Investigadora Visitante at the Unidad de Ciencias Sociales of the Centro de Investigaciones Regionales Hideyo Nogúchi of the Universidad Autónoma de Yucatán and a member of a two year seminar on Sexuality, Reproductive Health and Gender in Yucatán funded by the Ford Foundation.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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This dissertation was submitted to the Graduate Faculty of the Department of Anthropology, to the College of Liberal Arts and Sciences, and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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